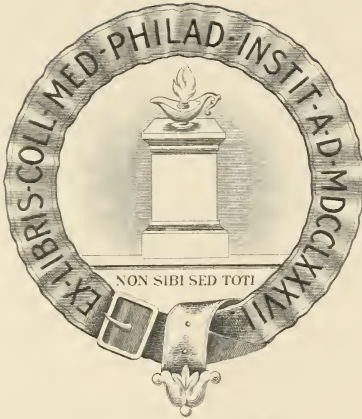


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Southern California Practitioner

VOLUME XXXI.

Editor,
DR. GEO. E. MALSBARY

Associate Editors,
Dr. Walter Lindley, Dr. W. W. Watkins, Dr. Elbert Wing, Dr. Ross Moore,
Dr. George L. Cole, Dr. Cecil E. Reynolds, Dr. Wm. A. Edwards,
Dr. Andrew W. Morton, Dr. H. D'Arcy Power, Dr. B. J. O'Neil,
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Dr. Edward T. Dillon, Dr. C. G. Stivers,
Dr. Boardman Reed.

Founded in 1885 by Walter Lindley

500 AUDITORIUM BUILDING
LOS ANGELES, CALIFORNIA
1916

WELLS FARGO BANK
TO
CASH ON HAND

SOUTHERN CALIFORNIA PRACTITIONER.

Vol. XXXI.

LOS ANGELES, JANUARY, 1916

No. 1

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SENESCENCE IN SOUTHERN CALIFORNIA

BY WALTER LINDLEY, M. D., LOS ANGELES.

"The number of a man's days are at the most an hundred years," is the dictum of Jesus, the Son of Sirach, as recorded in the ninth verse, eighteenth chapter of Ecclesiasticus, several hundred years before the Christian era.

In 1775 Buffon, the naturalist, said:

"The man whose life is not cut short by accident or disease reaches everywhere the age of ninety or one hundred years."

Taylor, in his authoritative work on "The Law of Evidence," published in 1864, says:

"The legal presumption of life closes at the expiration of one hundred years from the date of birth."

Thus we have established by the highest authorities that, for thousands of years, regardless of the advance in sanitation and dietetics, while the average longevity of man has been materially increased, the extreme span of life has remained unaltered.

Senescence is evidently controlled by an irrevocable law, over which neither science nor climate has any appreciable effect.

Buffon observed that a dog completed

its growth in two years and lived until he was ten to fourteen years, the horse reached maturity in size at four years and lived from twenty to twenty-five years, while man completed his growth in twenty years and, if free from disease or accident, lived from ninety to one hundred years.

From these premises we have Buffon's law—slightly modified—that every animal normally lives from five to seven times its period of growth.

In the normal life of man, cell reproduction continues from infancy on until very old age, when it ceases in one part of the body after another until finally, near the one hundredth year, the cells stop reproducing themselves in every part except the hair and nails.

Los Angeles does not claim that a residence here will extend the span of human life beyond the limit that has been fixed for thousands of years, but in Southern California, the efficiency of man lasts years longer than in more rigorous climes, or in climates which, although warm, have a heavy rainfall, resulting in much standing water, mosquitoes and malaria.

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Does the man who has reached sixty desire twenty-five or thirty years more of useful life?

Uselessness, inefficiency, despondency is worse than death.

Euripides, three hundred years before Christ, said:

“But whoe'er can know,
As the long days go,
That to live is happy, hath
found his Heaven.”

To live in the full sense of the word, not simply to exist, that is heaven on earth.

Cicero said:

“Old men, of all things, should especially be careful not to languish out their days in unprofitable idleness.”

To preserve this efficiency the man of advanced years should live in the climate where neither cold nor rain will keep him housed up in a vitiated, debilitating atmosphere.

The average annual rainfall in Los Angeles is fifteen inches, and there are places in Southern California where the average is less than five inches.

Why Man Should Live Longer

The average annual rainfall in Jacksonville, Fla., is over 53 inches; New York City, 46 inches; Cincinnati, 42 inches, and in Asheville, N. C., over 40 inches.

This gives some idea of the great number of days when the sun shines in Los Angeles.

The civilized world knows that the winter climate of Los Angeles is delightful, but comparatively few are awake to the fact that the summers are still more enjoyable.

Situated but twenty or thirty minutes from the ocean, with the purple mountains looking down upon us from fifteen miles to the east, and with the pepper (the glorious, graceful, umbrageous pepper), the palm, the eucalyptus and many other varieties for our shade trees, and the beautiful orchards of the fig, the lemon, the orange and the walnut all

about us, what could be more entrancing than a Los Angeles suburban landscape in both summer and winter?

Those getting on toward seventy should get away from worries, strains and anxieties.

Where could you more thoroughly escape all that is sordid and depressing than in a Los Angeles bungalow in the center of an acre with these surroundings?

Do you wish to be still busier?

Secure a larger tract of land and put it under intense cultivation.

Between times there is no more perfect joy than a hammock or an easy chair and a book under the fern-like foliage of a pepper tree.

The man nearing three-score and ten should eat of meat sparingly or not at all, but here from this acre he is provided every week of the year with ripe fruit, nuts in abundance from three or four walnut trees, vegetables of all varieties (green peas for the Christmas dinner), while a cow and a few chickens will do the rest.

Does he want fish for Friday?

The ocean is almost at the door. This is the ideal diet for the man who desires to prolong his days of usefulness.

This bungalow should have a sleeping porch, and winter and summer this man of many years, as well as the child of few years, should sleep outdoors, inhaling, all night long, the pure, dry air that comes over the mountains from the desert to the east.

Dr. Samuel Johnson, in that noble book, “*Rasselas, Prince of Abyssinia*,” draws on his vast knowledge and his rich imagination to describe an ideal valley where

“The sides of the mountains were covered with trees, the banks of the brooks were diversified with flowers, and every month dropped fruit upon the ground. All the diversities of the world were brought together, the blessings of nature were collected, and the valley,

wide and fruitful, supplied its inhabitants with the necessities of life."

Oh! if dear Dr. Johnson could have only walked through one of the thousands of gardens in Los Angeles and vicinity, with Mrs. Thrall on one side and Fanny Burney on the other, he could have exclaimed:

"This far surpasses my most vivid imagination."

What would twenty more productive years of Dr. Johnson's life have meant to the world?

In my own circle of acquaintances here in Southern California is one woman, who, at 105 years of age, is able to attend and enjoy religious and social gatherings; another woman, who is 102; and a stalwart lawyer, who, at 93, goes daily to his office.

My paternal grandmother died here a few years ago, age 97, while her brother, my great-uncle, died, age 94, a short time since.

He was a well-known Southern California banker, and attended to his du-

ties as bank president until a few weeks before his death.

Are you sixty?

If so you have probably accomplished the task you set yourself to do. Then come to Southern California and make the last twenty-five years of your life comfortable, happy and useful.

Do not spend your summer nights trying to find a cool place in your bed, or your winter days around a radiator.

Come to Los Angeles and spend your summer nights in comfort under a blanket, and your winter days in the life-giving sunshine, where you can, every day, pluck an orange and a rose.

These semi-tropic surroundings, with reasonable occupation, will make you independent to the end, the evening journey a source of pride and not a burden to your descendants, and, as you for the last time face the sun setting in the Occident, you will have the blessed satisfaction of having made the most of that cycle of life that was, by the Creator, placed in your care for one hundred years.

ADDRESS OF THE RETIRING PRESIDENT*

BY DR. TITIAN COFFEY, LOS ANGELES.

Mr. President and Members of the Society:

In looking over the work accomplished by our society during its first year of life, I think the society may well congratulate itself upon a most successful year. Personally, its success has been of extreme gratification to me, for as many of you know, an attempt to start such an organization as a branch of the Los Angeles County Medical Society was made some years ago and died an untimely death after three or four meetings. This was largely due to the fact that no one felt a personal interest in the organization and our meetings com-

ing as a section, as they did, under a larger society, were few and far between, hence the gratification of the organizers of the present society over the success of our past year. We have held, since the meeting of organization in May of 1914, nine meetings, at which eighteen papers have been presented. These papers have all been of fine scientific character, showing interest and thought on the part of the writers, and many of them have been of extreme interest and benefit. Our meetings have been well attended, the general average out of a membership of fifty being about twenty-nine. We have had a number of guests on various occasions and one evening in February, 1915, was of especial interest when Dr. Henry New-

*The Los Angeles Obstetrical Society, November 23, 1915.

man, of San Diego, consented to appear before the society and gave a talk with stereopticon views. Our membership has been full throughout the year and many inquiries have been made to me personally, and in fact to all the members of the society by those interested and who might wish to become members.

In the organization of the society the committee appointed to draft the constitution and by-laws made it quite worth while to become a member of the society, but no measures were taken for the elimination of dead wood aside from dropping them upon occasion of absence. This, however, has been rectified by a change in the by-laws which now gives the society more control as to the members. The society starts on its second year of work under most favorable auspices. Our membership is practically full, I think there only being three vacancies, and there are a number interested who are very desirous of becoming members.

The success of the society depends upon the activities of the individual members. The officers cannot make the society without the co-operation and

help of every member and as the retiring president I want to ask you to keep the interest of the society and its welfare at heart. Keep on the lookout for live members and get them in. I deem it of utmost importance that the society live closely up to its by-laws and eradicate the dead wood from its membership, for this simply acts as mistletoe upon a tree and will eventually kill any society, no matter how flourishing at first. One other thing that I would call to your attention before closing, is the advisability of presenting patients and especially pathological specimens before the society whenever possible. We all meet at some time or other with unique and interesting cases and secure interesting specimens which are of value to ourselves and our friends, and the free discussion among the members of the society adds much to the scientific value of our meetings.

I again wish to express my thanks and appreciation for the honor conferred upon me in making me your first president and wish to assure you that in retiring from the chair, no member will have a more keen or deeper interest in the welfare of this society than I.

POSTPARTUM CARE OF THE MOTHER*

BY F. D. FAIRCHILD, M. D., LOS ANGELES

Henry F. Lewis, in the opening paragraphs of his chapter on management of puerperium in "Peterson's Obstetrics," brings out a few truths which I want to give you by way of introduction to this paper. In general he says:

"Normal labor, and normal conditions after labor, are conditions of good health. However, the conditions may readily change to those full of pathology. Therefore, the puerperium, even after a perfectly normal labor, is the borderline between health and disease.

A puerperal woman corresponds to one who has just passed through some serious surgical procedure. The soft parts of the genital tract have received unavoidable bruises and often more or less extensive lacerations. For some hours the mother has been undergoing severe physical and nervous strain. Suddenly the abdominal pressure has been reduced; she has lost a quantity of blood; she will lose more blood, and her body fluids will be reduced through the lochia, milk and sweat. In short, her resistance has been considerably reduced. She is in a favorable condition

*Read before the Los Angeles Obstetrical Society, January 11, 1916.

for sepsis and the germs of infection are close at hand. With this condition always present to a greater or lesser degree, we should always keep in mind two or three things in the care of the woman during the puerperium, namely: cleanliness, rest and nutrition.”

In this brief paper I shall speak only of the care of the mother during the puerperal state, and try to touch on those points which we may meet with in any case.

We shall first consider the normal labor. The babe has been born, the placenta expelled and thoroughly examined. Ergot has been administered and the nurse or assistant is keeping a firm but gentle pressure on the fundus. All soiled articles, such as towels, sheets, dressings, etc., are replaced with clean ones. In cases at home this may be accomplished by previously boiling the towels, sheets, etc., or they may be immersed in one to one thousand bichloride solution, or one per cent lysol, for ten or fifteen minutes.

Examination for laceration of the perineum and sphincter ani muscles should be most carefully made, and laceration of these muscles does not always mean laceration of the mucosa and skin. The mucous membrane of the introitus is carefully examined for lacerations, and to do this a good light is necessary; an ordinary head mirror is very convenient. It may be necessary to pack the upper portion of the vagina with gauze to give a clear field for examination. Examinations of the cervix are often unsatisfactory, due to the great laxity of the tissues, and should not be made except under the strictest aseptic conditions, and then only when there is suspicion of rupture of the cervical artery or other serious injury.

I remember hearing a physician say once that he had confined a thousand or more women and never had a laceration. As a matter of fact, he never examined the patient to see. In the

matter of the repair of lacerations there is some division of opinion—some preferring to wait for twenty-four hours; others (and I think they are in the vast majority) favoring immediate repair, providing the patient is in condition to stand it. The repair of a lacerated perineum, whether immediate or after six months, is a surgical procedure and should only be done with the greatest care and attention to asepsis. The use of an anaesthetic in the immediate repair depends largely upon the condition of the patient, the amount of laceration and the surrounding conditions. The tissues should be carefully approximated, and the needle passed deeply into the sides of the laceration so that the separated muscle is sure to be included in the suture. Interrupted sutures, I think, are always preferable. Suture material should be medium hard catgut, and of a size sufficiently large so that slight tension will not cause the suture to cut through the bruised tissues. Where the tear extends well up the posterior wall of the vagina, it is quite essential to get the first suture well toward the upper end of the tear, care, of course being taken not to pass the needle through the wall of the rectum. For approximating the skin in perineal tears I prefer a medium silk worm gut or some non-absorbable material, the ends of which sutures are left long and encased in a sterile dressing of gauze or rubber tube. Where the ends of the non-absorbable sutures are cut short the sharp ends are the source of a great annoyance to the patient. Small tears in the vulvar mucosa may be closed with fine catgut, and this should be done to lessen chances of infection. Vaginal douches should not be used unless there is some special indication for them, and then only by a trained nurse or by the attending physician himself.

The application of an abdominal binder is another point upon which there is some disparity of opinion. In

my own practice I have always used it, both for the comfort that it gives the patient and to counteract a possible negative pressure which might arise from a sudden emptying of the uterus. I use a straight binder of firm material, at least eighteen inches in width. This is pinned up the front, beginning at the lower margin and pinning the binder firmly and smoothly upward. A pad should be placed over the fundus of the uterus, unless the contraction is very good. The perineal strap, three or four inches wide, keeps the binder from rolling up around the waist and also holds the vulvar pads in place. If there has been perineal repair the knees should be hobbled.

Any soiled clothing of the patient should be replaced with clean, dry clothing, the patient placed in a clean bed, which has been warmed, and a hot water bottle applied to the feet. If an anaesthetic has been used there should be plenty of fresh air in the room, and in many cases I think it advisable to use the pneumonia jacket for twenty-four hours.

In complicated cases all that has been said thus far, of normal cases, is equally applicable. If forceps have been used even more care should be exercised in looking for tears, especially those running far back on the recto-vaginal partition. Lateral tears are more often found where high or axis-traction forceps have been used. Mucous tears around the anterior fourchette are more frequent after the application of forceps.

If the patient has been under an anaesthetic for any length of time the same precautions should be used as after any other surgical operation, namely: external heat, stimulation, pneumonia jacket and fresh air.

In post partum hemorrhage we have one of the most serious complications which the obstetrician is called upon to combat. Ergot has already been given

as a routine measure. Is the uterus well contracted and can the fundus be felt distinctly through the abdominal wall? What is the character of the bleeding—is it steady or spurting? Was the placenta and membranes complete? Are there tumors of a fibroid nature in the body of the uterus or pedunculated on the inside of the uterus? Is your patient a bleeder? These questions, and others, are ones which the physician has to answer in every case of excessive flowing in the first twenty-four hours after labor. A steady flow of blood comes either from the interior of the uterus or from mucous tears in the wall of the vagina. A strong pulsating flow would probably indicate rupture of the cervical artery. Careful examination of the afterbirth should be a well formed habit with the physician, and will nearly always tell him whether there is a possibility of bleeding from that source. The presence of an interstitial fibroid condition in the uterus is very hard to determine and may be the cause of severe bleeding after labor. A pedunculated fibroid attached to the inner wall of the uterus may arrange itself in such a manner as to prevent firm contraction of the uterus, or may actually lodge in the cervical canal, thus holding it open. I well recall one such case that I had, in which I nearly lost my patient before I discovered the tumor. For several hours after labor bleeding was profuse, the uterus was well contracted and there was no lessening of the flow by the administration of ergot. I packed the vagina tightly with sterile gauze, which checked it for a short time. On removing the gauze and examining with a Graves speculum I found a mass lodged in the cervical canal; I tried to remove it with a placenta forceps but could not. With a large, dull loop curette I managed to get in behind the mass and tear it loose from its attachment to the uterine wall. The mass was a pedunculated

fibroid, about three inches in length by an inch and a half in diameter, and the stem was attached about midway. After the removal of this, all excessive bleeding stopped and the patient made an uneventful recovery. Post partum hemorrhage, if of mild degree, can usually be controlled medically by the use of hemostatics, massage of the uterus, ice or pressure of the abdominal aorta, and elevation of the foot of the bed. In more severe cases surgical procedure, such as the packing of the cavity of the uterus with sterile gauze, or the clamping and tying of the cervical artery if ruptured, or the curetting of the interior of the uterus, may be necessary. It takes only a short time for the patient to be fairly well drained of blood. This loss may be in a measure returned to the patient by the use of normal salt solution under the breasts, per rectum or intra-venously, as indicated and as best given under the circumstances. In extreme cases transfusion of blood may be necessary to save the patient's life. Strychnia, caffeine, camphorated oil hypodermically, or a pint of black coffee in the rectum by the drop method, may help to tide the patient over the danger point.

Eclampsia usually manifests itself before labor, but occasionally it may come on very suddenly in the post partum period. When it does, active elimination through all channels should be at once instituted. In those cases in which eclamptic symptoms or even active eclampsia have been present before labor there should be no relaxation after labor of the efforts to bring the physical conditions back to the normal. A free post partum flow should be encouraged. Bowels and skin should be kept thoroughly active. Pulse rate should be kept well slowed down. Daily blood pressure readings and daily examination of the urine for the output of urea should be made. It is very satisfying in many of these cases to see the albumen rap-

idly diminish, the amount of urea to return toward normal; the blood pressure readings soon begin to swing back past the danger point. Oedema, eye symptoms and headache disappear, and the patient once more assumes a healthy look and color.

Version I will mention only as a factor in infections which may occur during the puerperium, especially where the combined method has been used.

Separation of the symphysis pubis may occur spontaneously in normal labor, or in the use of instruments, or may be produced surgically in order to enlarge the birth canal. Whichever way it occurs, it must be attended to afterwards. The main thing to avoid in bringing the parts together again is the pinching of the bladder or the urethra. A metal catheter inserted in the urethra and a slight downward pressure exerted will help to accomplish this. The separated pubic bones once brought together may be held in position by a binder or adhesive straps, or an operation may be done and the parts sutured with chromic gut, kangaroo tendon or wire.

Hemorrhoids is a complication arising after labor which may give the patient as much pain and discomfort as she has had during her labor. During the latter part of the second stage of labor the sphincter muscle has been widely stretched and the mucous membrane and wall of the anus forced out. Some of the small hemorrhoidal vessels may have ruptured and caused small hematomata. As the sphincter contracts these blood-filled pockets are caught on the outside and become very painful. They are often very difficult to replace and keep so from the relaxed condition of the tissues and the sphincter muscle. Local treatments in these cases often suffice. Ice often gives relief. I have been in the habit of using the fluid extract of hamamelis and glycerine, equal parts, applied to the painful area on cotton or sterile gauze. If this does not relieve

the patient it may be necessary to incise the pockets and evacuate the clots. Later a radical operation may be necessary to complete a cure.

Puerperal infection—so common a few years ago—is now comparatively rare. The conduct of labor is really a surgical procedure and the same precautions should be used as in a major operation. The public is becoming educated to the fact that cleanliness in the conduct of a labor case is a prime requisite. The use of rubber gloves, cleansing and shaving of the external parts and the non-use of douches as routine treatment are the main reasons for infection being so rare. During labor as few examinations as possible should be made, and those only with the greatest care and by the attending physician or a trained assistant whom he can trust. The patient should be instructed during the early part of her labor that she must not put her hands on or near the cleansed area. The danger of infection after labor is even greater than that during labor. The physician cannot be constantly in attendance and the patient may be left to the tender mercies of careless, unclean and ignorant attendants. The mother, mother-in-law, or practical nurse who does not know the first principles of surgical cleanliness can do more harm in five minutes than the physician can undo in as many weeks. Douches may be given against the doctor's orders and without any observance of the principles of cleanliness. Pads soiled from the urine and feces are left on the patient for hours at a time. The bedding and clothing of the patient may be soiled and left unchanged. The subject is altogether too large to go into thoroughly in a paper of this kind. The treatment of these cases is one which tests the skill and ingenuity of the physician. As soon as the first symptoms arise eliminative treatment should be instituted. Absolute rest and quiet and free early ca-

tharsis may abort more serious trouble. Ice over the abdomen in some cases may be indicated. If operative treatment has to be resorted to, it should be thorough yet as simple as possible, care being taken not to drive infection deeper into the tissues. Too often, even after these cases apparently recover from the acute condition, the patient returns to you or someone else in the course of a few months with a well developed tubal infection, and this usually means more or less radical operation.

I have gone over briefly some of the events and complications arising in the first few hours following delivery. Now we shall consider the general care of the patient. In the first place, the patient should be kept absolutely quiet and have perfect freedom from all the worries of the household. This is one great advantage of having the patient in the hospital. The lying-in chamber should be a bright, sunny, airy room, the most cheerful room in the house. The labor has been more or less hard; even an easy one is a severe nerve strain on the mother, and she should have chance to rest and relax. The flow is a physical drain, and she should not be worried by the babe, which should be kept in another room. No visitors should be allowed. The mother's diet, while light for the first forty-eight or seventy-two hours, should be nourishing. No alcoholic stimulants, unless specifically indicated, should be used. After the bowels have been moved on the second or third day the diet may be increased to soft, depending on the condition of the breasts. As soon as the breasts have become filled and are free from any congestion solid food may be given, omitting such things as may influence the milk or hinder its digestion by the babe.

A breast binder should be applied early, before the breasts have begun to fill. The babe is not put to the breast until from six to twelve hours after

labor, depending upon the nature of the labor and the amount of flow or contractibility of the uterus. The breasts should be thoroughly cleansed with soap and water daily, and the nipples cleansed with boric acid solution, or 50 per cent alcohol followed by sterile water, before and after nursing. The babe's mouth should be kept thoroughly cleansed with boracic acid. The babe should not be left at the breast after it has finished nursing, or sore nipples may be the result. Thrush may come from dirty nipples in breast babies as well as in bottle fed babies. The breast pump should be rarely if ever used, and massage of the breast practiced only by a trained person. If the breast become caked, ice should be applied and a firm binder used. Abscess of the breast may occur early or late, so I will not go into it at all except to say that if cleanliness is carefully practiced few cases will occur.

In the care of the genitalia cleanliness is far more than godliness. In the first few days following delivery pads are changed as often as soiled. External douches of one to four thousand bichloride solution, followed by sterile water, or lysol solution—one dram to one quart—should be used about every four hours, or as much oftener as needed to keep the parts free from contamination by urine and feces. If a practical nurse is on the case instruct her as to the care of the parts after an evacuation of the bowels. The parts should be cleansed away from the vulva and perineum. Stitches should be kept free from rectal discharges and wrapped in sterile gauze if they have been left long. The nurse should not have her hands about the genitalia, only as absolutely necessary, and then only after thorough cleansing. Vaginal douches I do not sanction at all unless some special indication arises, and then only under very low pressure, and should be given only by the physician or a trained

attendant. The vagina should not be entered unless absolutely necessary and only under the most sterile conditions possible.

The abdominal binders should be applied as soon as the general toilet of the patient is completed. This should be unfastened and readjusted twice daily. It should be wide enough to reach from the epigastrium well down over the hips and of firm material. A many tailed or scultetus bandage is very good. The binder serves to keep the uterus well contracted, gives the patient comfort and replaces in a measure the negative pressure produced in the abdomen by the emptying of the uterus.

I have always made it a rule to keep my patients in bed twelve days, and off their feet from fourteen to eighteen days if possible, but this is not always possible. After the first few hours the patient may turn from side to side, and during the second week I have her turn on her stomach and lie face down for fifteen to twenty minutes two or three times daily. She may move about freely in bed unless the presence of badly lacerated perineum contraindicates.

Perineal stitches, if not absorbable, are removed on the ninth day if not infected. If they are infected they are removed as soon as the infection is discovered.

To primiparae particularly it is well to give more or less general advice as to the care of themselves after they are out of bed. Their diet should be simple and nourishing and free from those things which might disturb the digestion of the milk by the babe. They should avoid exposure to drafts, sudden chilling of the hands, feet or body, and the bowels should be kept in good condition. The same general care of the breasts which has been observed during their period in bed should be continued. The abdominal binder may be worn for a couple of weeks and then a properly

fitted corset worn in its stead. Heavy lifting, and sweeping of carpets or rugs should be avoided. An afternoon nap should be taken to allow the system, which has undergone such a severe strain, a chance to recuperate.

I have not attempted to cover the whole field in this paper, but only to bring out such things as we are liable to meet any day and have to contend with in any case of labor.

4521 Central avenue.

ECLAMPSIA*

BY DR. P. O. SUNDIN, LOS ANGELES

Eclampsia is one of the most important toxemias of pregnancy and the one complication, which we should exert all possible care to guard against since it is well considered one of the most dangerous.

As to causation there is much speculation but none definitely proven. Numerous investigators have isolated various bacteria, others believe the condition due to uremia caused by pressure on the ureters by the gravid uterus.

Hepatic changes are usually primary while kidney affections may be primary or secondary.

The generally accepted theory is that eclampsia is a toxemia, but whether the toxin originated in the intestinal canal, the contents of the gravid uterus, the liver or ductless glands remains for future investigators to determine.

As to pathology: Edema or congestion of convulsions, hemorrhagic areas, cerebral softening with thrombosis are common findings.

The kidneys show severe congestion, cloudy swelling, fatty degeneration of epithelium, thrombosis of the glomerulae as well as small veins and arteries. The heart muscle is fatty and also shows thrombi, necrosis and hemorrhagic areas.

Emboli are common in small vessels in the skin, lungs, and brain, but the most characteristic and constant changes, however, are to be found in the liver. Thrombi are numerous in

the portal veins and near them are to be found albuminoid degenerations, while the periphery of the lobules show fatty degeneration.

Some of the predisposing causes are acute and chronic diseases of the kidneys, abnormal enlargement of the uterus, large fetus. Retention from pressure on ureters, muscular rigidity in older patients, limited pelvic space in the very young.

Primiparae are affected about three times as often as multiparae. It occurs most often in the last three months of pregnancy and in about one out of six hundred pregnancies.

Oftentimes the exciting causes are abrupt suppression of urine, exhaustive labor pains, rigid os, constipation, excessive emotions in women of nervous temperament.

Symptomatology

The pre-eclamptic state is one which every patient should be informed of when she entrusts herself in the physician's care. Every one of us can recall cases which have shown traces of albumen following a test, upon being informed of such symptoms as unaccountable headaches, fullness in ears, dizziness, pain in epigastrium (the last named is probably the most common symptom), nervousness, insomnia, dimness of vision and other eye conditions.

The above mentioned prodromal symptoms having been overlooked or unrecognized by the patient, in fact absent in many cases though often lasting sev-

*Read before the Los Angeles Obstetrical Society, December 14, 1915.

eral hours or days. The next more impressive set of symptoms will follow: Blind spells of short duration, accompanied by twitching of the eyelids, staring, contraction, followed by dilatation of the pupils, rolling of the eyeball upward, twitching of facial muscles.

The now suspecting patient is fortunate if immediate vigorous treatment can be instituted or the inevitable stage of tonic convulsions will follow, in which contraction of head, neck and trunk produces opisthotonic curve, also clutching of hands, rigidity of arms and flexing knees. There is frothing and often the tongue is caught between the teeth. Usually there is no respiratory motions during this attack, which lasts about one-quarter of a minute and is accompanied by unconsciousness.

Now follows a rapid succession of clonic convulsions or spasms of muscles of the entire body, causing facial distortions, rapid opening and closing of the jaws and noisy respirations. This stage having lasted one or two minutes, coma follows, from which consciousness and sensation are slow to return.

Upon awakening the patient may be perfectly conscious or is bewildered. In five minutes to half an hour or more another attack may come over the patient. Record of more than 100 convulsions have been reported. Fever sets in and pulse becomes rapid. Labor sets in in about 60 per cent of cases.

Marked albumenuria, cast and blood are the rule, although anuria may be present.

Treatment

As to treatment there is a division into two great forces, the one advocates active interference, the others stand for an expectant plan coupled with elimination and mediactions.

The albumenuric patients who come to us early in their pregnancy rarely give us much trouble. They readily respond to diet, hot baths and purgation, especially when subjective symptoms

are mild, the urea is normal or not far from, the quantity of albumen little, with skin active and blood pressure not excessive. This class of patients should, however, be warned to follow a salt-free, restricted diet and occasional calomel purge, and should be especially guarded during the rest of the term.

The explosive cases, which are more apt to occur after viability, are the most dangerous and require heroic measures. If convulsions have not set in, absolute rest, lavage of the stomach and rectum, morphine, chloral, calomel, starvation or a strictly milk diet may convert the case into one of favorable outlook.

If, however, the above treatment makes no impression, early delivery by induced labor is indicated. This may be done by catheter, bags or digital.

Most writers seem to agree that if convulsions have set in emptying of the uterus at the earliest possible time is indicative, though the fatality of eclampsia does not depend so much on the pressure or number of convulsions as much as it does the degree of toxicity. The cardinal signs by which we judge the toxicity are: quantity of urine, highly bloody urine, absence of lucid intervals between convulsions, high pulse-rate, i. e., 120-plus.

Fortunately labor often sets in simultaneous with first convulsion so that manual dilatation, catheters or dilating bags readily finish nature's attempts. Morphine or chloral may be used for restlessness while ether, nitrous oxide or gas may lessen the severity of the convulsive seizures when exhausting. Venesection in plethoric patients and drawing of ten to fifteen ounces when high blood pressure, though some prefer to do this after delivery.

There is another class of patients in which we have a darker outlook. The uremic symptoms have come on suddenly, the convulsions are frequent and severe, there is no lucid intervals, coma

is deep and lasting in spite of blood letting, eliminative treatment and attempts at medications. If these cases are under seven months and cervix not too rigid, Vaginal Cesarean section is probably of choice or forcible dilatation and version.

If primipara is in last few weeks of time, cervix long and rigid, in order to be delivered in least possible time with least trauma Abdominal Cesarean is often the choice.

Williams, DeLee and Edgar all place mortality at 20 per cent. Fetal mortality at 20 to 50 per cent. All are believers in accouchment forcé or immediate delivery.

Stoganoff, of St. Petersburg, reports 360 cases personally treated with a mortality of 6.6 per cent. His treatment consists of irrigations, lavage, chloral per rectum in large doses, and morphia. Six hundred other cases have been reported by other Russian physicians with same treatment with a mortality of 8 per cent.

The writer in his limited experience has had seventeen cases under personal observation. In only one was accouchment forcé employed, and this, too, is the only one that died, so I find myself evidently a member of the class which believes in conservative or expectant treatment. All cases were made hospital cases from the start. Eliminative treatment immediately started and chloral in large doses per rectum. Have always resorted to slow, careful, manual dilatation and bags.

Earliest possible natural delivery without undue disturbance to patients seems to be obtained by thorough dilatation immediately after convulsions when patient is still under ether anaesthesia. Also colonic return—flow sodium bicarbonate irrigations, or flushings followed by Murphy drop method.

Nitrous oxide will probably take the place that chloroform and ether has had

in the past for the control of convulsions.

The Dublin method of treatment is quite generally employed in Europe, i. e. the swing is away from rapid dilatation and delivery. Eliminative treatment and medication in all its forms are employed, letting labor establish itself with little or no assistance.

The tendency among the American obstetrician is toward early emptying of uterus, Vaginal Cesarean being especially favored.

MORBUS SABBATICUS.

Morbus Sabbaticus, or Sunday sickness, a disease peculiar to church members.

1. The symptoms vary, but it never interferes with the appetite.
2. It never lasts more than twenty-four hours.
3. No physician is ever called.
4. It always proves fatal in the end—to the soul!
5. It is becoming fearfully prevalent, and is destroying thousands every year.

The Attack comes on suddenly every Sunday; no symptoms are felt on Saturday night; the patient sleeps well and wakes feeling well; eats a hearty breakfast, but about church time the attack comes on and continues until services are over for the morning. Then the patient feels easy and eats a hearty dinner. In the afternoon he feels much better, and is able to take a walk and read the Sunday papers; he **eats a hearty supper**, but about church time he has another attack and stays at home. He wakes up Monday morning refreshed and able to go to work, and does not have any symptoms of the disease until the following Sunday.

Remedy—"Be not deceived; God is not mocked."—Gal. vi:7.—Free Tract Society (Interdenominational), 736 San Pedro St., Los Angeles, Cal.

PHYLACOGEN IN PNEUMONIA

Perhaps no disease has baffled medical treatment to a greater extent than has lobar pneumonia. It must be conceded that as yet there is no true specific for the disease. The mortality from this type of pneumonia is high as compared with that of most other infectious diseases. In view of these facts, any agent that nearly approaches the specific in lobar pneumonia should be welcomed by the medical profession. Pneumonia Phylacogen is believed to merit that distinction.

In the use of Pneumonia Phylacogen, as in that of the various other Phylacogens, observance of certain details of administration may have an important bearing on the results. The product may be administered either subcutaneously or intravenously. The first dose should invariably be given subcutaneously. Injections should be made slowly—as slowly as possible, in fact. When injections are made hypodermatically the needle should not be allowed to enter the superficial fascia or muscular tissue. Certain patients, it has been found, do not absorb Phylacogen, when subcutaneously administered, with sufficient rapidity to produce the desired effect. Such cases will usually respond promptly to small doses given intravenously.

Large initial doses should be avoided. One Cc. will usually be suitable for the initial subcutaneous dose, and for debilitated persons it is well not to exceed $\frac{1}{2}$ Cc. The increase in dose should be gradual—usually $\frac{1}{2}$ to 1 Cc. per diem, depending upon the effect of the previous dose upon temperature and pulse rate, and only when these have again become normal should another injection be made.

The initial intravenous dose, which should always be preceded by one or more doses subcutaneously, should not be more than $\frac{1}{8}$ to $\frac{1}{4}$ Cc. (say 2 to 4 minims). Subsequently the dose may

be increased by $\frac{1}{8}$ to $\frac{1}{2}$ Cc. each day, according to the general indications, avoiding if possible the production of a marked constitutional reaction.

Pneumonia Phylacogen, which is supplied in 10-Cc. rubber-stoppered glass vials, is preserved with an antiseptic, and, with ordinary care, will not deteriorate as a consequence of exposure due to opening the vial. None of the material need therefore be wasted.

CORYZA—ACUTE NASAL CATARRH

This condition is manifested by a local congestion of the nasal mucous membrane, with an infiltration of serum into the tissues and later an exudation on the part of the mucous membrane.

The local treatment calls for a remedy capable of relieving the engagement by exosmosis, which can never be achieved by the use of acid or astringent preparations.

The use of Glyco-Thymoline in these cases purges the mucous membrane, relieving the congestion, and then by stimulating the local capillary circulation to renewed activity prevents a re-engorgement.

RACHITIC CHILDREN

The value of cod liver oil in rachitis has been so thoroughly demonstrated that there can scarcely be any question on the score of therapeutic efficiency, so the only problem arising in the use of cod liver oil in rachitis would be on the point of palatability, and if Cord. Ext. Ol. Morrhuæ Comp. (Hagee) be adopted then this is at once settled. Cord. Ext. Ol. Morrhuæ Comp. (Hagee) contains the essentials of the crude oil—the elements that give to the oil its well marked therapeutic and nutritive properties.

We advertise only such goods as may be of value to you in your practice. You are doing yourself and your patients an injustice if you do not read our advertisements carefully.



DR. ROSE BULLARD

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EDITORIAL

DR. ROSE BULLARD

Dr. Rose Talbott Bullard, one of the most prominent women in the medical profession in the west, passed away December 22, 1915, at the California Hospital, a few hours after a surgical operation for the relief of peritonitis. Born in Birmingham, Iowa, April 16, 1864, receiving her early education in the public schools of Birmingham and later attending the Birmingham Academy and the Northwestern University, Dr. Rose Bullard graduated from the Woman's Medical College at Evanston and was valedictorian of her class. In 1886 she came to Los Angeles with other members of her family, and engaged in the practice of her profession until a few days before her untimely death. In 1888 and 1889 she studied along special lines in Vienna and Göttingen. She was married in 1888 to Dr. Frank D. Bullard, and to this union was born a

daughter, Miss Helen Bullard. She also leaves two brothers, J. C. Talbott, of 1000 Maple avenue, and Dr. W. W. Talbott, of Butte, Mont.; and two sisters, Dr. Lula T. Ellis, of this city, and Mrs. S. A. Maxwell, of Monrovia.

After a special course in the College of Physicians and Surgeons, Chicago, Dr. Rose Bullard took special work at the Johns Hopkins University, Baltimore, and in 1907 she became instructor in gynecology in the Medical Department of the University of Southern California. She was a member of the regular County, State and American Medical Associations, and also of the American College of Surgeons. For five years she was secretary of the Young Women's Christian Association in Los Angeles, for one year she was its president, and at the time of her death she was a member of its board of managers. She was also a member of the Friday

Morning Club and of numerous other organizations.

The editor joins a host in feeling keenly this loss, for Dr. Rose Bullard had the admirable attributes of a true woman and sincere physician. Her life has had an influence for good that cannot be measured. To her bereaved ones we extend our sympathies.

DR. JOHN ADAMS COLLIVER

The president-elect of the Southern California Medical Society, Dr. John Adams Colliver, needs no introduction to the medical profession of Southern California. That you may possibly know him better, we give here some of our notes regarding his activities.

John Adams Colliver, A.B., M.D., Los Angeles, Cal.

Was for ten years a member of the faculty of the Medical Department of the University of Southern California, now the Los Angeles branch of the University of California.

Three years professor of physiology, six years chief of clinics, three years instructor in pediatrics.

Two years attending physician at Children's Hospital, Los Angeles.

Two years attending physician at Children's Home Society.

1906, assistant at Babies' Hospital, Dr. Emmett Holt clinic.

Ten years physician to Juvenile Court.

Student in following places: Cook County and Presbyterian Hospitals, Chicago; Bellevue, New York Post-Graduate, Vanderbilt Clinic, Foundling, Babies and Willard Parker Hospitals of New York City; Great Ormond Street Hospital for Children, London; Pfundler's Clinic, Munich; voluntary assistant in Prof. von Pirquet's Kinderklinik, Vienna; one and one-half years in European Children's Clinic and Hospital.

Following are some of his articles:

Relation of Blood Pressure to Therapeutics (Southern California Medical

Society.) We believe this was the first article in California on the subject.

Ingestion of Fluids in Chronic Nephritis (Blood Pressure Study—Los Angeles County Medical Society).

Cardio-Vascular Effects of Nitro-Glycerine (research) (Los Angeles County Medical Society).

Cardio-Vascular Effects of Adrenalin (research) (Southern California Medical Society).

Traumatic Meningeal Abscess (Pacific Coast Association of Railroad Surgeons).

Patent Foramen Ovale in Child 11 Years Old. Case reported Los Angeles County Medical Society.

Early Diagnosis of Pneumonia in Infancy (Southern California Medical Society).

Medical Side of Juvenile Court Work. (Address before California State League of Municipalities, San Diego.)

Does Abnormal Condition of Teeth Contribute to Juvenile Delinquency? (Read before Los Angeles County Dental Society.)

Does the Correction of Physical Defects in Juvenile Criminals Have Any Effect Upon Their Moral Conduct? (Southern California Medical Society).

Physical Basis for Irritability in Boys—The Beginning of Juvenile Delinquency. Given under the auspices of the Riverside County Medical Society in joint session with probation officers, judge of juvenile court, school teachers and school board. Reprinted by New York State Probation Commission, also few thousand reprinted by National Probation Commission.

Early Symptoms of Poliomyelitis with Special Reference to a New Preparalytic Symptom. (Read before the Symposium Medical Society, November, 1912.) Published by California State Journal.

A New Preparalytic Symptom of Poliomyelitis. (Published in American Medical Journal, March 15, 1913.)

Obscure Manifestations of Rheumatism in Childhood. (Read before California State Medical Society, April, 1913.) Published in Archives of Ped.

Psychological, Physiological and Social Study of Delinquent Children. (Address given at meeting of the National Association of Charities and Correction in joint session with children's work.)

Cutaneous Regional Variation in the Pirquet Reaction. (Research work done in Prof. von Pirquet's Kinderklinik, Vienna.) Published in Archives of Ped.

Pediatric Situation in Europe and the Effects of the War on the Same. (Given before Symposium Medical Society and San Diego County Medical Society.) Published in California State Journal.

Obscure Manifestations of Otitis Media in Infants and Children. (Read before Southern California Medical Society.)

OFFICE ASSISTANTS

Office attendants and assistants of various kinds call upon us, seeking positions. We do not like to fill our pages with their advertisements, but if you are in need of such help and will drop us a card we will be glad to refer those to you that appear to us suitable. Of course we will expect you to not hold us responsible for any misfits, unless we give a personal recommendation, for most of these applicants are strangers to us. They usually come well recommended and present more or less evidence of ability and trustworthiness, so that we are impressed that it would well be worth while for you to communicate with us if in need of such help.

MEDICAL BUILDING SUIT

The Medical Building Corporation stockholders' liability suit to collect on the \$35,000 corporation note to the Los Angeles Trust and Savings Bank came to trial before Los Angeles Township

Justice Brown January 4, 1916. On examination of the plaintiff's witnesses it developed that the note had been paid to the bank by the endorsers giving a new note. The action against the defendants was therefore dismissed.

DIVISION OF HEALTH

The proposed charter for the city of Los Angeles provides for twelve departments, number seven being a Department of Public Welfare with seven divisions, one of which is a Division of Health. What do you think of that? There are Departments of Finance, Public Works, Public Safety, Public Service, Public Utilities, Harbors, Public Welfare, Library, Parks, Recreation, Civil Service, and of Municipal Art. But the health of Los Angeles is a matter of such minor moment that it is relegated to a division, along with the Divisions of Charities and Corrections, Employment, Humane Treatment of Animals, Research and Social Betterment, Housing, and the Division of Legal Aid. The Health Officer will be Chief of the Division of Health, under the Director of the Department of Public Welfare. It will be a most dignified position, just about equivalent to that of Dog Catcher.

CONSOLIDATION

The Physicians Drug News and Office Practitioner has been acquired by the Critic and Guide Company and will be consolidated with the Critic and Guide beginning with January, 1916. The consolidated journal will remain under the editorship of Dr. William J. Robinson.

THE FACTOR OF POVERTY IN SANITATION

The factor of poverty in sanitary problems was discussed in Washington, November 26, by Surgeon-General William C. Gorgas, whose success in cleaning up Havana and the Panama Canal zone have brought him recognition as

America's leading sanitarian. His audience was the Clinical Society of Surgeons, assembled in their twenty-fourth annual meeting. Dr. Gorgas said, in part:

"Such sanitary work as is necessary in the tropics is inexpensive, but measures directed against special disease are not the greatest good that can be accomplished by sanitation.

"Before these great results that we can all now see are possible for the sanitarian, we shall have to alleviate more or less the poverty at present existing in all civilized communities. Poverty is the greatest of all breeders of disease and the stone wall against which every sanitarian must finally impinge.

"During the last ten years of my sanitary work I have thought much on this subject. Of what practical measure could the modern sanitarian avail himself to alleviate the poverty of that class of our population which most needs sanitation? It is evident that this poverty is principally due to low wages; that low wages in modern communities are principally due to the fact that there are many more men competing for work than there are jobs to divide among these men. To alleviate this poverty two methods are possible, either a measure directed toward decreasing the number of men competing for jobs, or, on the other hand, measures directed toward increasing the number of jobs.

"The modern sanitarian can very easily decrease the number of men competing for jobs; if by next summer he should introduce infected stegomyia mosquitos at a dozen different places in the southern United States he could practically guarantee that when winter came we would have several million less persons competing for jobs in the United States than we have at present. This has been the method that man has been subject to for the last six or seven thousand years, but it does not appeal to me, nor, I believe, to yourselves. This

method is at present being tried on a huge scale by means of the great war in Europe. I do not think that I risk much in predicting that when this war is over and we shall have eliminated three or four million of the most vigorous workers of Europe, wages will rise and for a long time no man will be unable anywhere in Europe to get a job at pretty fair wages.

"But I am sure that every sanitarian would much rather adopt measures looking toward the increase of jobs rather than, as we have done in the past, submit to measures that decrease the number of competitors for jobs.

"I recently heard one of the members of the cabinet state that in the United States 55 per cent of the arable land, for one reason or another, is being held out of use. Now suppose in the United States we could put into effect some measure that would force this 55 per cent of our arable land into use. The effect at once would be to double the number of jobs. If the jobs were doubled in number wages would be doubly increased. The only way I can think of forcing this unused land into use is a tax on land values.

"I therefore urge for your consideration, as the most important sanitary measure that can be at present devised, a tax on land values."

PREVENTION OF BLINDNESS

Despite unfavorable weather a large audience was present at the annual meeting of the National Committee for the Prevention of Blindness, held at the Academy of Medicine, New York City, November 4, 1915. Hon. Joseph H. Choate, one of the honorary vice-presidents, presided, and the meeting was addressed by Honorary President Wm. H. Taft, Mr. Choate, and Dr. George E. de Schweinitz, professor of ophthalmology, University of Pennsylvania. Dr. de Schweinitz's paper was

a fine contribution to the literature of the conservation of vision movement, and it is hoped that this paper will be available in published form in a short time. The managing director made report of the activities of the first nine months and showed the favor in which the service of the National Committee is held throughout the country. Nearly 80,000 of the committee's publications have been distributed in the nine months since its organization.

Large publicity has followed the holding of this annual meeting, the account of it being carried in several of the news services of national scope and many editorial references to the committee's work have been noted.

New members of the committee are being enrolled daily. Every person to whom this news letter comes is invited, if he is not already a member, to join the committee and support it to such extent as he feels inclined. A membership card is sent with every news letter and persons receiving this card who have already become members are requested to pass it on to some person who ought to be a member of the committee.

The medical inspection of school children, while in force to considerable extent in seventeen states, is to have increasing attention during the coming year on the part of legislatures which are to be in session, and it is hoped that in many states where regulations are not now in force a change for the better may be effected before the close of 1916.

The Survey, October 9, 1915, carried an article on "Saving the Sight of Babies," by the secretary of the National Committee, and the Modern Hospital for November, 1915, an article on "Trachoma in the United States," by the field secretary.

Alabama

The Infant Welfare Association, Birmingham, has done splendid work

with the infants visited during the summer. Every case of ophthalmia found by the visiting nurse has been given immediate attention.

Arizona

The assistance of the National Committee for the Prevention of Blindness has been requested in dealing with an outbreak of trachoma among the school children in Jerome, Ariz. The disease was first noticed there a year ago by Miss Katherine Kraft, a city nurse, and with the co-operation of the local health officer an attempt was made to stamp out the disease at that time. This year, however, a larger number of school children were affected, and the co-operation of the State Board of Health is now being sought in an endeavor to eradicate the disease before it spreads further. Jerome is a mining town of a population of about three thousand and is contiguous to a number of Indian reservations. According to the figures of the United States Indian Service, about 24 per cent of the Indians in Arizona are afflicted with trachoma. It has been suggested that in trips to Jerome for supplies the disease has thus been communicated to the whites.

A press ditspatch from Douglas, Ariz., states that systematic inspection and treatment of pupils affected with trachoma is wiping out the disease in the schools of that city. Whereas seventy-eight cases were discovered there last year and placed under observation and treatment, only five are being taken care of now. Only four new cases were discovered this year. It is interesting to note that in each instance the children having trachoma are new arrivals from other towns, chiefly Mexican. A systematic inspection of the school children as to eyes, nose, throat, lungs, etc., is made by the school physician and the school nurse follows up these cases and sees that the children are properly cared for. Great improvement in the health of the school children of Douglas has

been noted since this inspection was put in force, and teachers report that there is less absence on account of disease this year than before in a period of several years. Medical inspection of children is considered responsible for this greatly-to-be-desired result.

California

Several cases of trachoma have been reported and the State Board of Health has taken precautionary measures to prevent a spread by prohibiting children suffering from the disease from attending school.

The Bureau of the Hygienic Laboratory of the State Board of Health is making purchases of silver nitrate outfits, similar to those distributed by the New York State Board of Health. The outfits, together with a copy of the new ophthalmia neonatorum law, will be mailed to every physician in California at an early date.

Idaho

The State Board of Health has a ruling which has the effect of law for the proper routine treatment of babies' sore eyes. Enforcement of the rule, as usual in sparsely settled communities, is quite difficult. Dr. Ralph Falk, secretary of the State Board of Health, Boise, writes: "We furnish silver nitrate without cost to physicians and midwives."

Kentucky

That the Kentucky legislature, when it assembles next winter, will be asked to pass a bill requiring the annual examination of all children in the public schools by the teachers in charge of them in order to detect diseases or defects of vision, was the announcement made by Miss Linda Nevill, secretary of the Kentucky Society for the Prevention of Blindness, within the past month.

In a recent bulletin of the State Board of Health of Kentucky, devoted to "Prevention of Trachoma," we find the statement made a number of times that

trachoma exists not only in the eastern section of the state, but is also found to considerable extent in the Blue Grass country and through the south and west. Dr. John McMullen, U. S. Public Health Service, and Dr. A. T. McCormack, who have been making a survey of conditions in Kentucky, have recently been making examinations of the eyes of school children in a number of the hitherto unvisited cities. Their investigations have shown that there is scarcely a community where trachoma may not be found. For instance, in Henderson, 81 pupils were excluded from the schools on account of trachoma; in Hopkinsville, 46 cases were found among 500 children examined; in Paducah, 97 cases were found out of 728 pupils examined. In fact, in practically every school visited the number of children found with this disease, either well developed or in an incipient stage, was far beyond expectations.

Massachusetts

The thoroughness with which the United States government does its work and the kindly attitude toward the immigrant are indicated by the special attention given to an Italian girl afflicted with the dreaded eye disease, trachoma, and who has been detained at the immigrant station for some months. A rare and delicate operation was performed on her eyes and indications seem to point to the success of the operation and to the girl's ultimate release.

The Massachusetts Commission for the Blind is continuing the study begun last year into the condition and education of children with defective sight in the cities of Lawrence, Springfield and Worcester; and similar investigations are now well under way in Cambridge, Lynn and New Bedford. In Lawrence the superintendent of schools will go seriously into the question of a special class for children with defective eyesight as soon as the problem of placing the school children in the overcrowded

public schools has been met. In Springfield a teacher has been chosen who has made some study into methods of teaching children with defective sight and is now interviewing the parents of children recommended for a defective eyesight class, so as to secure their consent to having their children transferred into a special class, which it is proposed to open shortly. In New Bedford the question of a special class for children with defective sight has been taken up by the school committee and also by the superintendent of schools, and a class will probably be started after the Christmas vacation.

It is the policy of the Massachusetts Charitable Eye and Ear Infirmary, in exceptional cases recommended by the Boston Board of Health, to admit mothers with children suffering from ophthalmia neonatorum. This makes it much easier for the Board of Health to transfer serious cases to the Eye and Ear Infirmary and also insures the continuance of maternal nursing. Arrangements are also made for the babies to receive breast milk in cases where the mothers are not admitted.

Michigan

In order to promote and demonstrate modern advances in factory betterment, the Detroit Board of Commerce has established an Industrial Welfare Bureau. This department will create a permanent exhibit of material illustrative of better industrial relations. The work will correspond in principle and effect to that undertaken by the National Civic Federation and the American Museum of Safety in the East.

Exhibits have been promised already from more than 100 factories, including several of the great national plants which are conspicuous for their approach to ideal industrial factory conditions. The National Committee for the Prevention of Blindness has been asked to supply the Bureau with its

new exhibit on Industrial Accidents to the Eyes.

Missouri

The seventh of a series of lectures on medical subjects, given by members of the faculty of the Medical School of Washington University under the department of nursing and special service, was delivered by Dr. John Green on "Diseases of the Eye".

New Jersey

The New Jersey State Commission for the Blind is proceeding along the lines indicated in previous editions of this News Letter, and during the past month a number of popular educational meetings have been held. Exhibitions of the work of the blind in New Jersey were held at Newark, New Brunswick and Camden, and the attendance was good. In Newark and New Brunswick an illustrated lecture was also given on "Prevention of Blindness" and the support of the churches and organizations represented is assured for the appeal which the Commission is to make at the next session of the State Legislature for an annual appropriation for preventive work.

New York

In co-operation with Buffalo Department of Health, the school authorities and others, a study is soon to be made of present conditions in schools, factories, etc., which have any bearing upon the preservation of eyesight. Where improvements are indicated an effort will be made to introduce them in order that the resultant conditions may be taken as a model for adoption in other communities. This study will be conducted by the National Committee for the Prevention of Blindness and it is expected will serve as the basis of a special report showing ideal work in this line of activity. This will be one of the publications of the National Committee and it is hoped the service may be accomplished within the next nine months.

The Metropolitan Life Insurance Company has issued an educational leaflet, entitled "Mother, Baby and Midwife", which warns prospective mothers against the employment of untrained midwives and also gives instructions concerning the prevention of blindness through proper care at the time of a baby's birth. The material was prepared in co-operation with the New York State Committee.

During the Rochester Week for the Blind, under the auspices of the Rochester Association of Workers for the Blind and the New York State Commission for the Blind, there were distributed a large number of Publications No. 1 and No. 3, of the National Committee, and the Wood Alcohol circulars prepared by the New York State Committee.

The New York State Department of Health, which has been making aggressive efforts to safeguard the sight of infant citizens in New York has recently added to its birth certificate the following reminder:

"Physicians are required to report ophthalmia neonatorum (babies' sore eyes) to local health officer within twenty-four hours from the time when first seen. Sanitary Code, Chap. II, Reg. 1. A midwife, nurse, or other person having charge, must report immediately to health officer or physician inflamed, reddened eyes of infant under two weeks.—Penal Law, Sec. 428."

The Department has also made known to physicians, health officers, nurses and midwives throughout the State that it intends to leave nothing undone toward wiping out the scourge of unnecessary blindness, and has reminded the members of these various groups of the legal requirements imposed upon them, and has strengthened this by a personal appeal for their assistance and co-operation.

The New York State Committee for the Prevention of Blindness in extend-

ing its public educational work is organizing local committees in co-operation with the County Medical Societies or local Academies of Medicine throughout the state. Such committees are actively at work in New Rochelle, Rochester, and Oswego.

The purpose of these local bodies is to have the subject of prevention of blindness presented before the largest possible number of audiences during the year in order to create a public opinion which will make it possible for the health officers to secure more complete reports upon babies' sore eyes and when necessary to provide care for reported cases. They will promote the establishment of adequate nursing and hospital facilities for babies' sore eyes when these are lacking.

These committees are also concerning themselves with the inspection of school children's eyes both for infections and refractive errors, and will endeavor to secure adequate treatment and, where necessary, glasses for such children as are unable to supply these for themselves.

The daily papers and magazines at home and abroad have contained accounts of numerous instances of more or less serious injuries to the eyes from the explosion of the central rubber sac filled with strong solutions of alkalis contained in some sorts of golf balls. Popular attention in this way has been drawn to the dangers from alkalis in these much used balls. It is reported that the victim from Amagansett, Long Island, will recover, although it was feared he would lose his sight.

Dr. S. S. Goldwater has resigned as Commissioner of Health of New York City and has been succeeded by Dr. Haven Emerson. Dr. Goldwater has performed signal service in controlling the sale and use of wood alcohol, thereby preventing not alone blindness but death from poisoning by this spirit.

In the Weekly Bulletin, Department

of Health, New York City, October 9, special mention is made of refractive errors in childhood. As a result of nearly 500 complete and careful refractions performed at one of the department's clinics the request is made that every child before beginning school life should have its refraction estimated. If correcting glasses are required, they should be worn. The following conclusions are presented:

"In accordance with the observations of previous investigators, myopia or short sight is a condition rarely present at the beginning of school life, gradually increases with the age of the child, so that at the age of sixteen years, almost one-half of our cases had more or less myopia."

"If a child has a high degree of hypermetropic astigmatism, mixed astigmatism, or myopia of medium degree, with vision after correction, of only 20/50 or less, it should be placed in special classes with a curriculum that minimizes the amount of near work. There should be close co-operation between school authorities, school nurses, school doctor on the one hand, and ophthalmologists on the other."

North Dakota

Preventive work in North Dakota has received a decided impetus due to the recent activities of Mr. B. P. Chapple, Superintendent of the State School for the Blind, Bathgate. At a recent meeting of teachers from all sections of the State, Mr. Chapple delivered an address on causes and prevention of blindness, eliciting enthusiastic interest and the assurance of co-operation from all those present. Exhibits on babies' sore eyes, midwives and trachoma were loaned by the National Committee for this occasion.

Ohio

It is reported by the Industrial Commission that in the year 1914 there were 768 rejections of applicants by the industrial establishments of Ohio which

maintain systematic examination of applicants for work. One of the most common causes for rejection was impaired vision, 202 cases.

The following is quoted from the Bulletin of the Board of Health, Cincinnati, Ohio, for week ending September 18, 1915:

Concurring in Professor R. B. Irwin's recommendations, the Board of Education will establish another special class for the benefit of those children whose vision has been impaired to such an extent that they can not, with safety, participate in the regular classes. Last May a standard for admission was submitted by a local Committee and adopted.

The following patients may, therefore, be referred to the conservation of vision classes:

1. Children who can not read more than 6/60 at distance, and who can not read 2.00 at 20 C.M.

2. Myopes under the age of fourteen who have more than eight diopters of myopia.

3. Hyperopes who have symptoms of asthenopia and who have more than eight diopters of hyperopia.

4. Children who have an astigmatism of more than 3.5 diopters and whose vision can not be brought up more than 6/24.

5. Children with maculae, nebulae, leukomae, which interfere with sight and lead to eyes strain.

6. Children with interstitial keratitis, uveal or corneal disease under treatment, who have been withdrawn from regular classes.

7. The committee assumes that these conditions exist after the proper refractions have been made.

These children are to have special nursing service if the budget for 1916 passes.

Cincinnati has established its second conservation of vision class and is about to form another. During the last

two years in this city 3,475 children with defective vision were noted by the school doctors, and of this number, 1,779, or 51% were wearing glasses on or before June 20, 1915.

The superintendent of schools in Cincinnati has taken steps to procure the efficient and adequate lighting of the rooms used for Night High Schools.

Dr. Wm. H. Peters, Chief Medical Inspector, states that in Cincinnati all reported cases of inflammation of the eyes of the new-born are investigated with prompt dispatch. At October 15, 47 cases had been referred to the district physicians and nurses. Lost vision was limited to one eye, in one case.

Oklahoma

According to dispatches from the local press of Tulsa, Oklahoma, it is noted that Mr. Charles Page, a millionaire oil operator of that state, will establish at Sand Springs a semi-charitable Eye Hospital and Sanitarium at a cost of \$200,000. The institution will consist of several buildings covering about eighty acres. There will be distinct units for whites, Indians and negroes. Trachoma, with which disease the clipping states, about 75% of the Indians of Oklahoma are afflicted, will receive special attention. The institution will be under the management of Dr. Daniel W. and Dr. Peter C. White, who for years were the Government trachoma experts, working among the Indians of Oklahoma.

Pennsylvania

The Pittsburgh Association for the Blind continues its effective service for prevention of blindness by use of exhibits and frequent lectures in various parts of Western Pennsylvania. Mr. W. W. Stamm, the Executive Secretary, in his lectures on "Occupations for the Blind," loses no opportunity to enforce the teachings of prevention.

A number of Publications No. 1, No. 3 and No. 5, were used in connection with an exhibit of social work at the

Pennsylvania State Conference of Charities and Corrections held in Scranton, Pa., October 21, 22, and 23.

Rhode Island

A special effort to lessen the number of cases of infant ophthalmia in Providence, Rhode Island, is being made by Superintendent of Health Dr. Charles V. Chapin and hereafter physicians and midwives who fail to report cases of the disease which comes under their observation will be held accountable by the health department. In his letter to physicians, stating that ophthalmia neonatorum is a notifiable disease, Dr. Chapin requests every case in which "one or both eyes of an infant are noticed to be inflamed or with a swelling or reddening of the lids and an unnatural discharge, or reddened at any time within two weeks after its birth" to be reported immediately to the Health Department. The Providence Department of Health sends a nurse to visit every case attended by a midwife immediately upon receipt of the birth certificate. This is, of course, an important measure in the prevention of blindness from babies' sore eyes, as the nurse learns herself whether or no there is any inflammation. The effects of this visiting are, however, confined to midwife cases alone.

Tennessee

The campaign against preventable blindness in infants in the state of Tennessee is being pushed enthusiastically by the several organizations that inaugurated the movement in Nashville. A pamphlet has been prepared giving the new state law on the subject, outlining the methods of preventing blindness in infants, and laying emphasis on the importance of the subject. The pamphlet has received the endorsement of the State Board of Health as well as of the Nashville health authorities. It was produced under the general auspices of the Council of Jewish Women, whose work for

the prevention of infant blindness is carried on in Tennessee under the leadership of Mrs. John P. Frank. The Parent Teachers' Association of Nashville is rendering hearty co-operation and an effort is being made to interest the daily and weekly press of the state in securing publicity for the suggestions offered in the pamphlet.

Texas

A committee from the Parent-Teachers' Association of Texas City have requested the co-operation of the school board in the employing of a specialist to examine the eyes of all the public school pupils, inasmuch as a number of the pupils heretofore have been found to be effected with trachoma.

West Virginia

A hospital for the treatment of trachoma has been established at Welch, McDowell County, West Virginia, by the West Virginia Health Council, with the co-operation of the United States Public Health Service. The health authorities decided to establish the hospital at Welch, as it was found that trachoma was widely prevalent in that county, but cases from any part of the State will be treated there.

Wisconsin

Plans are now being made by the Committee for the Prevention of Blindness of the Wisconsin Association for the Blind which will result in a State-wide educational campaign beginning shortly after the first of the year, which it is hoped will promote widespread interest in the preventive work.

Under the guidance of Miss Carrie B. Levy, the work of the Association has been successfully carried on for a number of years. Preventive work has been materially aided by the generous co-operation of Milwaukee oculists, and others throughout the State, who have given freely of their time and service. An extensive educational program is to be carried out, a number of physicians and laymen prominent in the work of

prevention of blindness having promised their support to the movement.

NEW OFFICERS

The following officers of medical societies have been recently elected:

Los Angeles County Medical Association

Dr. C. H. Whitman, president; Dr. C. C. Browning, vice-president; Dr. George H. Kress, secretary-treasurer, and Dr. Stanley Black, Dr. Walter Brem, Dr. L. M. Powers members of the council.

Fresno Medical Society

President, L. R. Willson; first vice-president, Drs. H. J. Craycroft and H. J. Staniford; second vice-president, Dr. J. H. Pettis; secretary, Drs. C. D. Sweet and H. J. Staniford; treasurer, Dr. T. M. Hayden; fifth member of the board of governors, Drs. G. H. Akins and C. B. Collins; delegates to state society (three), Drs. G. A. Hare, A. B. McConnell, W. P. Miller, C. D. Kjaerbye and J. H. Pettis; alternate delegates, E. J. Couey, W. P. Miller and C. P. Kjaerbye.

The committee to make arrangements for the meeting of the State Medical Society, which will be held in the Hotel Fresno, April 18-20, this year, follows: Drs. G. H. Aiken, T. M. Hayden, J. R. Walker, H. J. Staniford, D. H. Trowbridge, H. J. Craycroft and L. R. Willson. This committee has already begun planning the details to care for the convention.

San Diego Medical Society

Dr. John C. Yates was elected president of the San Diego Medical Society at the annual meeting. Dr. O. G. Wicherski was elected vice-president, Dr. A. J. Thornton was chosen secretary, and Dr. Robt. Pollock was elected a member of the medical council.

Stanislaus County Medical Association

The new officers of the association are: President, Dr. P. N. Jacobson of Turlock; vice-president, Dr. A. J. Young of Oakdale; secretary-treasurer, Dr. E. F. Reamer of Modesto. Dr. N. C.

Bissell was selected as delegate to attend the State Association.

San Joaquin Medical Society

The officers are as follows: Fred P. Clark president; Raymond T. McGurk, first vice-president; H. J. Bolinger, second vice-president; Dewey R. Powell, secretary-treasurer; C. R. Harry, delegate to the California State Society.

Following are the directors: Drs. C. R. Harry, F. P. Clark, D. R. Powell, J. D. Dameron, H. J. Bolinger, R. F. McGurk, Linwood Dozier, L. R. Johnson and G. W. Walker.

Several committees were appointed as follows:

Ethics—Drs. C. F. English, C. R. Harry, F. P. Clark, W. F. Priestley and B. J. Powell.

Admission—Drs. Hudson Smythe, D. R. Powell, E. A. Arthur, C. F. English and Linwood Dozier.

Finance—Drs. R. T. McGurk, Linwood Dozier and F. P. Clark.

Program—Drs. Linwood Dozier, R. T. McGurk and D. R. Powell.

El Paso Medical Society

Dr. E. R. Carpenter, president; Dr. W. H. Pickels, vice-president; Dr. C. F. Braden, secretary-treasurer; Dr. M. B. Wesson, editor of the society's medical

journal; Dr. L. G. Witherspoon, Dr. G. Werley and Dr. J. W. Tappan, censors; Dr. R. L. Ramsey, delegate to state medical society, and Dr. W. L. Brown, alternate.

Sonoma County Medical Society

President, Dr. F. O. Pryor, Santa Rosa; vice-president, Dr. Marion B. McAulay, Petaluma; secretary, Dr. W. E. Bixby, Sebastopol; treasurer, Dr. J. W. Cline, Santa Rosa; delegate to State Medical Society, Dr. F. E. Sohler, Geyserville; alternate, Dr. R. M. Bonar, Santa Rosa.

Alameda County Medical Society

Dr. David Haden was chosen president; Dr. W. H. Irwin, vice-president, and Dr. Elmer E. Brinkerhoff, secretary and treasurer.

The executive committee consists of Dr. Lemuel P. Adams, Dr. W. A. Clark, Dr. J. L. Milton, Dr. Pauline S. Nusbaumer, Dr. Alvin Powell and Dr. Dudley Smith.

Santa Clara County Medical Association

President, Charles B. Hare; first vice-president, D. R. Wilson; second vice-president, C. G. Wilson; third vice-president, Jonas Clark; secretary, J. A. Bacher, and treasurer, H. J. B. Wright.

EDITORIAL NOTES

Dr. Homer H. Sheffield has located at Vallejo.

Dr. G. M. Tralle has opened offices in Santa Ana.

Much ado about nothing: The Haiselden articles.

Dr. S. A. Ellis has returned to Azusa, 503 Azusa avenue.

Dr. C. Gilchrist is located at National City, in the Rice block.

Dr. G. K. Abbott has purchased the practice of Dr. R. M. Clark at Covina.

Dr. T. C. Donnell, Long Beach, has removed his office to the Marine Bank building.

Four physicians' offices were robbed in Modesto last month, presumably by drug fiends.

Dr. E. E. Endicott, of Jackson, Amador county, has located in the Elks' building, Stockton.

Dr. William R. Molony of Los Angeles has been elected president of the State Board of Medical Examiners.

Dr. Frank D. Bishop, of Long Beach, has sold his practice to Dr. W. B. Ryder, formerly of Clinton, Iowa.

Dr. C. L. Scott has been reappointed health officer of Kings county and his salary raised from \$400 to \$500.

Dr. Charles C. Browning and Dr. E. M. Brown have moved to the Merritt building, Eighth and Broadway.

Dr. W. L. Haworth has moved to Long Beach and will be associated with Dr. R. A. Terry, a former classmate.

Dr. Jackson Temple, of Santa Rosa, has let a contract for the conversion of his residence into a modern hospital.

Dr. A. R. Cooke has removed his office to Suite 508, Hollingsworth Building, Sixth and Hill Streets, Los Angeles.

Dr. Dennis F. Ragan, formerly City Health Officer of San Francisco, died December 20th at his residence, 1299 Haight street.

The Arizona State medical examination was held January 5th, at Phoenix, at which time nine medical students took the examination.

Dr. Lowell C. Frost and Dr. Otto M. Mueller have opened offices in the Palmer building, 6422 Hollywood boulevard, Hollywood.

Judge Reeve, of Los Angeles, declares that eighty-five per cent of the boys and girls declared wards of the local juvenile court are mentally defective.

The election of Dr. John A. Colliver as president of the Southern California Medical Society was a well merited recognition of faithfulness and ability.

Dr. Lyell C. Kinney has located in San Diego, with offices at Fourth and Elm Streets, where he will limit his practice to Roentgenology. We heartily congratulate San Diego.

Dr. J. T. Cummins is the new physician for the Mountain Copper Company, Redding, succeeding Dr. George W. Sevenman, who will enter hospital service in San Mateo.

It is reported that Sophie Anderson, a domestic, puts a valuation of \$25,000 on a blemish on her face, in a suit filed in San Francisco against Dr. G. Franklin Shields. Some face. She would seem to be a rather valuable domestic.

We note a number of clippings with prominent headings regarding 500 "chiropractors" preparing to fight the law that bars them from practice in this state. Didn't know there were that many "chiropractors" in California.

The Florence Crittenton Home, 234 East Avenue Thirty-three, under the presidency of Mrs. Mary E. Stoddard, is one of our worthiest institutions. Any person wishing details of work should send to above address, enclosing stamp, for announcement.

The Prescott, Arizona, Yavapai is running an interesting serial on "Must Learn How to Live," that could well be distributed in pamphlet form. It applies especially to tuberculosis, and shows the importance of hygienic schooling in such cases.

Riverside physicians seem to be too proud to have a "poor doctor" and too comfortable to answer inconvenient emergency charity calls for medical service. At any rate, a Mexican mother died during child-birth December 30th and no physician could be obtained.

The San Francisco Board of Health has elected Arthur H. Barendt president, this being his fifth consecutive term. Dr. William C. Hassler's appointment as health officer has been confirmed and made permanent. Dr. Louis

Roncovieri has been appointed Emergency Hospital surgeon, vice Dr. Alfred Roncovieri, resigned.

Dr. Edgar Bryant, owner of the Hahnemann Hospital, San Francisco, died December 30th as the result of an accident received at the closing of the Panama-Pacific Exposition. While watching the exercises from the roof of the California building he fell from a cornice and sustained a fracture of the base of the skull.

The Interstate Conference on Rabies was held in Winnemucca, Nevada, January 11th. Representatives were present from California, Nevada, Oregon, Utah, Arizona and the Federal government. The California delegates were E. T. Ross and Dr. R. A. Peers, appointed by the State Board of Health.

Los Angeles Police Judge White is to have the following "cabinet" composed of women to assist him in the disposition of female prisoners in police court: Mrs. O. P. Clark, Mrs. L. Coombs, Mrs. John Barton, Mrs. Leland Norton and Dr. L. Meyers, a woman physician of Long Beach. Wouldn't it simplify matters to have a woman appointed Police Judge for such cases?

San Diego comes forward with photographs of the patient, the physician and the x-ray plate, as evidence that a patient swallowed a ten-inch case knife, which was recognized by radiography and removed by the surgeon, Dr. George C. Amerson. No, it is not the usual San Diego diet. The patient declares she swallowed it in the delirium of a fever eight months before its removal.

Los Angeles is considering banishing the roller towel by legal enactment. The question was raised by Ira W. Allen, Jr., who applied for compensation from a local manufacturer and the Guardian Casualty and Guaranty Company, under the workmen's compensa-

tion act, on the ground that he had contracted a skin disease by using an office towel. Fortunately there are probably few roller towels remaining in Los Angeles to be removed by legal enactment or otherwise.

Health Commissioner L. M. Powers has issued his Annual Report for the year ending June 30th, 1915. It is replete with valuable and encouraging information. There were but 33 deaths from typhoid fever during the year. About one-half the cases were contracted outside the city and they were brought to Los Angeles for treatment. This is a remarkably favorable record for a city of over one-half million inhabitants.

Out of the many thousands of boys and young men who played football during the season that closed with Thanksgiving Day, 16 were killed. Of these only three were college students. One of the fatalities was in a boy 11 years old. Three others were 15 or under, while four more were only 17. The fact is football is a great game for developing our young men, but it should only be played by those who have had careful training and it is a crime for a boy under 17 to enter these contests.

It seems that Dr. G. Frank Lydston will be successful in inducing a general recognition of the American Medical Association as an Illinois association. The Illinois Supreme Court has affirmed the ruling of the Appellate Court, to the effect that the members of the present board of directors were elected illegally. Inasmuch as the association was incorporated under a charter from the State of Illinois, the directors must be elected at meetings held in that State. May the Association legally elect directors from its membership outside of the State of Illinois?

Members of the profession who were in Los Angeles fifteen years ago remem-

ber Dr. Smith L. Walker, who was interne at the California Hospital. Dr. Walker had a son about twelve years old. The following from a Halifax paper shows that both father and son are doing their duty:

‘A Truro Boy Heard From.—Captain Arthur L. Johnson, M.D., on the surgical staff of No. 1 Canadian General Hospital, Etaples, France, writing to his father, the editor of *The Wesleyan*, says: ‘Young Walker, of Truro, is in the operating room with me. He is a very valuable worker, competent and his attitude splendid.’ He is the son of Dr. Smith L. Walker, also serving in the Duchess of Connaught Hospital, England.’

Dr. Woods Hutchinson is writing daily popular articles on hygiene and allied subjects for the Hearst papers. He begins a recent article as follows:

‘Anybody who is stupid enough may become a criminal. Indeed, many criminals are actually born of feeble wits, and these of other feeble wits. One of the important new lights thrown upon the problem of crime was the discovery, by patient investigation of family records and neighborhood histories and police and jail and poor farm records, that a surprisingly large number of criminals were related to one another and to other criminals, not always directly, but through the medium of paupers or prostitutes or epileptics or habitual drunkards, or simple imbeciles and feeble-wits.’

There is one cure and only one cure for all of this, and that is the sterilization of the feeble-minded, the insane and the confirmed criminal. Let us never stop working with this object. It is the physicians duty.

The following were recently elected members of the Los Angeles County Medical Association: Dr. F. W. Rinkenberg, 514 Haas Bldg.; Medical Dept. of Univ. of Ill., 1906; Endorsed by Drs.

E. A. Trommald and J. W. Cline. Dr. M. Blanche Bolton, 517½ Beacon St., San Pedro, Cal.; Cal. Med. Coll., 1897; Endorsed by Drs. F. W. Reynolds and G. T. Van Voorhees. Dr. J. A. Metzger, 1112 Brockman Bldg., Los Angeles; U. of Pa., 1895; Endorsed by Drs. C. L. Lowman and Howard W. Seager. Dr. Marcia A. Patrick, 620 S. Flower St., L. A.; Rush Med. Coll., 1913; Endorsed by Drs. F. M. Pottenger and J. W. Richards. Dr. Karl M. Bonoff, 2734 W. 9th St., L. A.; Coll. of P. & S., U. S. C., 1914; Endorsed by Drs. Anders Peterson and E. M. Lazard. Dr. James Burton, 436 Chamber of Commerce Bldg., Pasadena; Albany Med. Coll., 1894; Endorsed by Drs. C. E. Phillips and R. B. Hill. Dr. Page Brown, 2713 Kenwood Ave., L. A.; Jefferson Med. Coll., 1879; Endorsed by Drs. Geo. G. Hunter and H. G. Brainerd. Dr. Joseph J. Carter, 1202 Brockman Bldg., L. A.; Rush Med. Coll., 1901; Endorsed by Drs. Bernard Smith and Harry M. Brandel. Dr. Eugene Stadelman, National Bank of Long Beach Bldg., Long Beach; U. of Pa., 1895; Endorsed by Drs. T. Percival Gerson and Charles E. Zerfing. Dr. A. W. Teel, Glendale, Cal.; Coll. of P. & S., 1895; Endorsed by Drs. A. M. Duncan and D. D. Nice. Dr. Karl Dieterle, 5810½ Pasadena Ave., L. A.; U. of S. Cal., 1914; Endorsed by Drs. Phil Boller and C. H. Criley. Dr. John C. Klutho, 1001 Investment Bldg., Los Angeles; Mo. Med. Coll., 1898; Endorsed by —. Dr. Charles E. Remaly, Kensington Apts., L. A.; U. of Pa., 1897; Endorsed by Drs. C. P. Thomas and Hugo A. Kiefer. Dr. Joseph G. Evans, 701 Marsh-Strong Bldg., L. A.; U. of Md., 1903; Endorsed by Drs. E. Avery Newton and C. W. Decker. Dr. Annie S. Bullock, Alhambra, Cal.; Women’s Med. Coll. of Pa., 1912; Endorsed by Drs. John M. Armstrong and C. B. Alexander. Dr. Samuel G. Bay, 611 Hollingsworth Bldg., L. A.; Ohio Med. U., 1898; Endorsed by Drs. F. D. Fairchild and John L. McDaniel.

BOOK REVIEWS

ANATOMY OF THE BRAIN AND SPINAL CORD. With Special Reference to Mechanism and Function. For Students and Practitioners. By Harris E. Santee, A.M., M.D., Ph.D., Professor of Nervous Anatomy in Chicago College of Medicine and Surgery, Medical Department of Valparaiso University; Professor of Anatomy in Jenner Medical College, Chicago; Member of Association of American Anatomists; Formerly Professor of Anatomy in the College of Physicians and Surgeons, Chicago; Medical Professor of Anatomy in Harvey Medical College, Chicago. Fifth Edition, revised and enlarged with 158 illustrations, 46 of which are printed in colors. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street. Price \$4.00 net.

The recent advances in human anatomy and its allied sciences necessitate the thorough revision this work has received. Every section has been largely rewritten in accordance with the discoveries of the past few years. Being designed for a text-book, the subject-matter is presented in the order found convenient to the dissector. The description proceeds from the gross structures to the constituent neurones in each successive region. Wherever the embryology will assist the student to comprehend the adult forms, the development is briefly given. The embryology is more fully interwoven with the regular text than in the fourth edition; and, probably because of this, the special embryologic chapter is omitted. The other chapters are elaborated and illustrated by a number of new histologic and diagrammatic drawings and are, therefore, somewhat enlarged, but the author has kept them within reasonable bounds. Some excellent illustrations also have been introduced from the fifth edition of Morris's Anatomy. The special objects held in view throughout the book are the location of functional centers and the tracing of their afferent, associative and efferent connections. Emphasis is laid upon the origin, course, termination and function of conduction paths as they are met in the regular study, and the more important and better known of

these paths are summed up in a final chapter on the tracing of impulses. Function is everywhere correlated with structure; and so far as present knowledge permits, the function of each group of neurones is given in connection with its anatomical description. The BNA nomenclature is followed almost without exception, the English equivalents of the Latin terms being very largely employed. Reason and experience show the fundamental value of the Basle Nomenclature of Anatomy. Minor details yet remain to be perfected; but the elimination of proper nouns and the adoption of correct descriptive names for all anatomic structures has already done a great service for science and been of vast assistance to the student. In the present revision the compound names of fiber-tracts are made more descriptive by placing first that element of the noun which represents the origin of the tract and that element last which indicates the termination of the tract. The noun is thus given added pedagogic value: it would perfectly express the facts, and is in accord with the descriptive requirements of the BNA Commission. The terms "Ventral" and "Dorsal" are used especially to designate local relation and direction within the individual columns of the spinal cord.

EMERGENCY SURGERY. By John W. Sluss, A.M., M.D., Associate Professor of Surgery, Indiana University School of Medicine; Ex-Superintendent Indianapolis City Hospital; Surgeon to the City Hospital. Third Edition, revised and enlarged, with 685 illustrations, some of which are printed in colors; \$4.00 net. P. Blakiston's Son & Co., 1012 Walnut Street, Philadelphia.

This volume is of especial value to the general practitioner, presenting modern surgical practice in concise form. In the present edition, the Section on Military Surgery has been entirely rewritten, to conform with the more recent surgical experiences.

THE PRACTICAL MEDICINE SERIES. Comprising Ten Volumes of the Year's Progress in Medicine and Surgery. Under the General Editorial Charge of Charles L. Mix, A.M., M.D., Professor of Physical Diagnosis in the Northwestern University Medical School.

Volume VI. General Medicine. Edited by Frank Billings, M.S., M.D., Head of the Medical Department and Dean of the Faculty of Rush Medical College, Chicago, and J. H. Salisbury, A.M., M.D., Professor of Medicine, Illinois Post-Graduate Medical School. Price \$1.50.

Volume VII. Obstetrics. Edited by Joseph B. DeLee, A.M., M.D., Professor of Obstetrics Northwestern University Medical School. With the Collaboration of Herbert M. Stowe, M.D. Series 1915. Chicago: The Year Book Publishers, 327 S. LaSalle Street. Price \$1.35. The price of the set of ten volumes is \$10.

THE NOSE, THROAT AND EAR. Their Functions and Diseases. A Treatise upon the Breath-Road, Food-Road and Accessory Organs. By Ben Clarke Gile, M.D., Instructor in Otolaryngology in the University of Pennsylvania and formerly Assistant in the Throat and Nose Dispensary of the University Hospital; As-Throat and Ear Dispensary Chief at the Presbyterian Hospital; Consulting Laryngologist in the Taylor Hospital and formerly Instructor in Otolaryngology in the Polyclinic Hospital and Post-Graduate School of Medicine, Philadelphia; Fellow of the American Laryngological, Rhinological and Otological Society. With 131 illustrations, eight of which are printed in colors. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street. Price \$2.75 net.

This Text-Book is systematically arranged and apparently designed especially for students. They will find the work quite an adjunct to their clinical work on the Nose, Throat and Ear. It is so thoroughly up to date that it affords a ready method of brushing up, for those practitioners who have not a great amount of time to give to these subjects.

THE MEDICAL RECORD VISITING LIST, OR PHYSICIANS' DIARY FOR 1916. Newly revised. New York: William Wood & Co., Medical Publishers.

This Edition of the Medical Record Visiting List has been revised to increase the amount of matter calculated to be useful in emergencies, and eliminate such as might better be referred to in the physicians' library. The most important change is in the list of remedies and their maximum doses in both

apothecaries' and decimal systems, and the indication of such as are official in the United States of America.

THE WORK OF OUR HANDS. A study of occupations for invalids. By Herbert J. Hall, M.D., and Mertice M. C. Buck. Published by Moffat, Yard & Co., New York. 1915.

We can readily agree with the writers, that "If the discharged and handicapped patients from hospitals all over the country could be given legitimate work which would secure them even half of the usual wage, a very great load would be lifted from charity, and a still greater load from the minds and hearts of the workers. There are many hard working families in which the burden of one idle member is a very serious matter. If that patient could be given work which would earn even a very small amount of money the difficult atmosphere of the home would be quite changed." It is a volume well worthy the serious consideration of the members of our profession, who must so often come into such intimate contact with those handicapped by invalidism. In chronic invalidism and prolonged convalescence, when time hangs heavily and tends to depress, a perusal of this work may convince the patient of his usefulness to society, thus dispelling the gloom and despair of those who might otherwise feel that their life's work is done.

SPEAKING OF OPERATIONS. By Irvin S. Cobb, author of *Back Home*, *Europe Revised*, etc., etc. Illustrations by Tony Sarg. New York: George H. Doran Company. Price fifty cents.

Our preformed doubts regarding the suitability of this monograph for the physician's waiting-room, have been dissipated by reading it. It is not morbid. It is hygienically, prophylactically funny. Cobb—this Cobb—is so human that we can forgive him for almost anything except associating whiskers with surgical ability. You read this essay, among numerous other contributions by Cobb, in the Saturday

Evening Post, and you will be glad now to have it in more permanent form for your waiting-room. The following extracts may refresh your memory:

"He was a good, keen, close diagnostician. How did he know I had only fifteen dollars on me? You did not have to tell this man what you had, or how much. He knew without being told."

"Anything doctors do in a mass is ethical."

"It never occurred to a mother that she should sterilize the slipper before spanking her offspring."

(Describing a fermented milk product) "Even before you've swallowed it, it tastes as though it had already disagreed with you. The nurse said this food was predigested but did not tell me by whom. Nor did I ask her."

Waldorf-Astoria Hotel, April 25, 1915.

Dinner. Tendered to Irvin S. Cobb. New York: George H. Doran Company.

We are glad to know that Cobb had dinner at the Waldorf-Astoria, though it cost at least one of his "friends" seven dollars and a half. Does that satisfy your curiosity? Want to know how he worked it?

PROGRESSIVE MEDICINE. A quarterly digest of advances, discoveries and improvements in the medical and surgical sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics, Materia Medica and Diagnosis in the Jefferson Medical College, Philadelphia; Physician to the Jefferson Medical College Hospital. Assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia; Ophthalmologist to the Frederick Douglass Memorial Hospital and to the Burd School; Instructor in Ophthalmology, Philadelphia Polyclinic Hospital and College for Graduates in Medicine. Volume IV. December, 1915. Lea & Febiger, Philadelphia and New York.

The physician who would continue to be progressive, needs Progressive Medicine. In the section on Diseases of the Kidneys, which is under the supervision of J. Harold Austin, M.D., Associate in Medicine in the University of Pennsylvania, we are told that

probably the most striking feature in the study of diseases of the kidney during the past year is the large number of investigations, for the most part clinical, but in some instances experimental, that have aimed at correlating with the clinical symptoms and post-mortem findings, one, or more often several, of the renal functional tests. As the result of the investigations our classification of nephritis has been rendered more precise and the value of the various functional tests has become more clearly defined.

LABORATORY METHODS. With special reference to the needs of the general practitioner. By B. G. R. Williams, M.D., Member of Illinois State Medical Society, American Medical Association, etc., and E. G. C. Williams, M.D., Formerly Pathologist of Northern Michigan Hospital for the Insane. With an introduction by Victor C. Vaughan, M.D., LL.D., Professor of Hygiene and Physiological Chemistry and Dean of the Department of Medicine and Surgery, University of Michigan. Third edition. Illustrated with forty-three engravings. St. Louis: C. V. Mosby Company, 1915. Price \$2.50.

The appearance of a third edition so soon bespeaks the appreciation of this practical manual. The chief additions we note are: Elastic tissue staining, Salting-out method for tubercle bacilli, A simple Gram stain, An invariable blood stain, A dressing for laboratory tables, besides a number of what may be regarded as minor changes.

DISEASES OF THE SKIN. By Henry H. Hazen, A.B., M.D., Professor of Dermatology in the Medical Department of Georgetown University; Professor of Dermatology in the Medical Department of Howard University. Two hundred and thirty-three illustrations, including four color plates. St. Louis: C. V. Mosby Company, 1915.

Hazen brings out prominently the commoner diseases of the skin, and emphasizes especially skin diseases in the Black Race. Aside from the four plates in color, it presents quite a gallery of new illustrations in black and white. Cuts of the more rare diseases have given way to photomicrographs illustrating the histopathology

of the more common skin lesions. It is a work that every dermatologist will want, and it will appeal strongly to medical students and those in general practice, because it is modern, brief and lucid.

DISEASES OF THE NOSE AND THROAT. By Algernon Coolidge, M.D., Professor of Laryngology in the Harvard Medical School. 12mo of 360 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1915. Cloth, \$1.50 net.

This is a good manual, well adapted to the requirements of students. That is to say, it is up-to-date, concise, and so written that it supplements, in a very practical way, the clinical work in laryngology.

WHOOPING-COUGH A SERIOUS DISEASE.

In an address before the New York Academy of Medicine, and reported in the Archives of Pediatrics, issue of August, 1914, John Lovett Morse, A.M., M.D., Professor of Pediatrics in the Harvard Medical School, made this significant statement: "The relative mortality from whooping-cough, scarlet fever and diphtheria is essentially the same throughout the country, whooping-cough being almost everywhere more fatal than scarlet fever and less fatal than diphtheria. . . . Instead of being a trifling affair, as it is usually considered to be by the laity, whooping-cough is a most serious and fatal disease. 'Any disease which kills 10,000 children per annum is,' as Rucker says, 'a serious one. If bubonic plague were to kill that many children in the United States in one year, the whole world would quarantine against our country. A child dead of whooping-cough is just as dead as a child dead of plague.'"

In the same issue of the journal above referred to, the editor, an undoubted authority, says that "whooping-cough causes more deaths in children under one year than any other infectious disease."

In view of these startling facts, is it not just possible that the profession at large, like the average layman, has been too prone to look upon whooping-cough as an inevitable concomitant of childhood, and to underestimate its seriousness?

The Bordet-Gengou bacillus is recognized as the specific cause of whooping-cough, and the most rational method of treating the disease is by means of vaccine prepared from cultures of this bacillus. It is pertinent in this connection to refer to two such vaccines which are manufactured and marketed by Parke, Davis & Co. One bears the name of Pertussis Vaccine; the other is designated as Pertussis Vaccine, Combined. The first-mentioned vaccine is indicated in cases diagnosed as pertussis, in suspected cases when a definite diagnosis is lacking, and as a prophylactic. The second is indicated in all cases of pertussis, but especially those which have persisted for some time, such infections being usually of the mixed type. The vaccines are administered hypodermically and are supplied in bulbs, in rubber-capped vials, and in glass syringes. The various packages are fully described in an announcement which appears elsewhere in this journal under the caption, "The Vaccine Treatment of Whooping-Cough." The advantages of the vaccine treatment are succinctly stated in the advertisement, which our readers are advised to consult.

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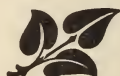
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A SURGICAL REPORT.*

BY REXWALD BROWN, M.D., F.A.C.S., SANTA BARBARA, CAL.

This is a review of three hundred and seventy-five major surgical cases which have occurred in my private practice at the Cottage and St. Francis hospitals of this city. Five hundred and fifty operations have been performed on these three hundred and seventy-five patients. It is my desire to enumerate these operations, grouping together those of the same kind, noting especially any of more than usual interest, to give results of the operations and detail somewhat the operative care of the cases. By so doing we hope to in some measure add to the growing confidence on the part of the public in the value of surgery in properly equipped hospitals more or less far removed from great medical and surgical centers.

Appendectomies.—One hundred and eighteen patients had removal of appendices. Fifty-six of these were of the chronic type, thirty-six were acute, twelve subacute, while fourteen were removed at patient's request during the course of other operations. In the series of acute and subacute types

there were five cases of general suppurative peritonitis, seven localized abdominal abscesses, and five gangrenous appendices. One acute case occurred in pregnancy and one in a strangulated inguinal hernia. In the series there were five deaths, two from toxemia in the general suppurative cases, two from paralytic ileus in abscess cases, and one from acute suppression of urine in a gangrenous case.

Herniorrhaphies.—Twenty-eight operations were done, twenty-two of them inguinal, four ventral and two femoral. The repair of the abdominal wall in the inguinal forms has been mainly that patterned after Andrews and Ferguson. There have been no recurrences.

Hysterectomies.—There were seventeen women upon whom abdominal hysterectomy was performed. Thirteen of the operations were performed because of fibroid tumors in the uterus, and four because the uterus was the seat of carcinoma. In the fibroid cases the technique followed is that devised by Dr. J. B. Murphy. One of these fibroid cases was complicated by a four months'

*Read before the Santa Barbara County Medical Society, January 10, 1916.

pregnancy. There were two deaths in this series, both from shock, one after a total removal for carcinoma, and the other after removal of a large multiple fibroid. Six patients had myomectomies.

Perineorrhaphies.—Forty-four were performed. Almost all of these were of the Emmett type. In this series fourteen repairs of the cervix were also done, and twenty-five curettements.

Suspension of uterus.—Were seventy-one in number. These were of various types: Baldy, Gilliam, and Kelly mainly. About half were done to remedy prolapsus conditions and the rest as part of the pelvic toilet after removal of Fallopian tubes. In cases with subsequent pregnancies no complications have occurred.

Operations on Tubes and Ovaries.—Thirty-three double and six single salpingectomies were performed for disease incident to infection at parturition and to the Neisser organism. There were thirty operations on the ovaries, mainly complete and partial removals of the organs, because of their involvement and destruction by the above infective processes. Seven patients had large cysts removed which had originated from ovarian and par-ovarian tissue. In two cases an ovary was transplanted into the abdominal wall.

Extra Uterine Pregnancy.—Four patients were operated upon for ruptured tubal pregnancy. One of these had active hemorrhage and was almost in extremis at the time. Recovery, however, was prompt. Two others had had repeated small hemorrhages following the original rupture, while in the final case a mummified foetus was found following a year's illness after the rupture.

Breast.—There were ten amputations of the breast, eight for carcinoma and two for multiple fibro cystic conditions. The radical operations preserved parts of the pectoral muscles after stripping them of their lymph bearing fascias. These parts later covered over the ves-

sels and nerves of the axillary spaces to prevent future edema, neuritis and loss of function from contraction of fibrous tissue. Results were excellent. There was one death in the series.

Prostate Gland, Bladder and Urethra and Testicles.—Eight prostatectomies were performed, six of them by the supra-pubic route. Two patients died, both over 70 years of age, having kidney and heart degenerations. One operation was performed for the removal of stone from the bladder. Two operations were on the urethra, one external urethrotomy for stricture and one repair for rupture of the urethra with extensive extravasation of urine. There were three operations for hydrocele and two orchidectomies.

Hemorrhoids.—Fourteen operations were performed, all by the clamp and cautery method.

Tendoplasties.—There were eight. Five were performed for repair of severed tendons at the wrist, one to lengthen tendons in the forearm, one to lengthen the hamstring tendons, and one transplantation of tendons in paralytic deformity of the foot.

Bones.—There have been fourteen operations for the repair of fractures of the long bones. Six cases had Lane plates used, five were wired, one nailed, and in two cases bone transplants from the other leg were used to secure union in ununited fractures of the tibia. In three cases, two of the femur and one of the tibia, severe infections occurred. The others healed by primary union with excellent results. Four patients were operated upon for fracture of the patella. All were treated by imbricating the capsule with chromic gut over the severed patella with most satisfying results. There were two operations for osteomyelitis of the tibia.

Joints.—Twelve operations were performed, one for bony ankylosis of the elbow, one exarticulation of the hip for osteomyelitis of head of femur, and ten for bunions. The technique used in

the bunion cases was that of the Mayos. The outcome in these cases has been extremely gratifying to the patients and myself.

Gall Bladder.—There were four cholecystotomies for the removal of gall stones, and one anastomosis between the gall bladder and bowel in a case of carcinoma of head of pancreas. This patient died.

Kidney.—There were four operations on the kidney, one the drainage of a large adherent hydronephrosis, one a double decapsulation in interstitial nephritis, and two for perirenal abscesses.

Stomach.—Three gastro-enterostomies were performed, two for carcinoma and one for ulcer. One carcinoma case died.

Intestines.—There have been fourteen operations, five for fistulo-in-ano, two resections of the caecum, two operations to relieve obstruction of the bowels, one suspension of the rectum, one appendicostomy, one colostomy, one repair of ruptured intestine, one ileocolostomy, and one separation of adhesions about caecum and terminal ileum for chronic intestinal stasis. Three of these patients died, the two resections, one of tuberculous and the other of chronic hemorrhagic infection, and the case of ruptured bowel with peritonitis, from the kick of a horse.

Tuberculosis.—There were three removals of the glands of the neck for tuberculosis, and two operations for tuberculous peritonitis.

The other operations were: three removals of carcinoma from axilla, upper maxilla and abdomen, two skin grafting cases, one removal varicose veins, one hair lip repair, one osmic acid injection for trifacial neuralgia, six Pozzi's on the cervix, one open tenotomy for torticollis, three amputations, two thyroid operations, one removal of the coccyx, one removal of dermoid of sacrum, one removal of parotid tumor, one removal of large lipoma of chest wall, two

evacuations of pelvic abscesses, and four exploratory laparotomies with findings of inoperable conditions.

Complications.—These have not been many. There was one acute dilation of stomach following a gastro-enterostomy, one severe secondary hemorrhage from an appendectomy incision, one parotitis following an appendectomy and ovarian resection, one thrombophlebitis of left internal saphenous vein after hysterectomy, one epididymitis after prostatectomy, a pleurisy after a gall bladder drainage, and one bronchopneumonia with lung abscess and death two months after a bunion operation. The records concerning wound infection are not accurate except in a recent consecutive seventy-five cases in which there have been none. In these seventy-five cases the technique of the operating room has been directed by a single nurse. The routine of detail has been uniform and careful. Previous to this series changes of nurses in the operating rooms were frequent and errors in asepsis were not uncommon. In this connection we appreciate that some infections come from the tissues of the patient rather than from introduction into the wound of germs from an outside source.

The total number of deaths in this series was twenty-two. Those not mentioned above were, one after the resection of the upper jaw for carcinoma, one after the operation to produce ankylosis after a fracture in a Charcot hip joint, and three after exploratory laparotomies.

The Operative Care.—This is as simple as can be made, it being desired to subject the patient to the least possible mental and physical stress. By frank discussion of the case an endeavor is made to strengthen the confidence of the patient in the operation to be undertaken. The advantages and disadvantages of the surgical procedures are weighed and the dangers compared with the dangers and discomforts of the dis-

eased condition. No patient is told "there is no danger at all."

Patients enter the hospital the day before the operation. A tub bath is given followed by two ounces of castor oil. A light evening meal is permitted. The area for operation is dry shaved, painted with iodine and covered with sterile gauze. The routine laboratory clinical tests are made by the resident pathologist.

The next morning enemas to cleanse the lower bowel are given. Exhausting purges and enemas are not permitted. One and one-half hours before operation an eighth of a gram of morphine is given by hypodermic, and one-half hour before operation the same dose is repeated with 1/120 grain of atrophine. Water to drink is freely allowed, and care taken that the bladder is emptied just before the patient goes to the operating room.

Ether is invariably used for the anesthetic because of its safety and the ease of its administration. The position of the patient on the operating table is of importance. Strain, especially of the sacro-iliac joints, is prevented by pillows placed beneath the lumbar regions. Just before operating the field is again covered with iodine and alcohol.

Nerve blocking by novocaine has been used considerably and it does seem to prevent, as is claimed for it, the bulging of the intestines into the wound. After the skin is opened towels are clamped to the edges to avoid contagion from the skin.

The operative technique is conducted with care to avoid unnecessary damage to tissues. Abrasions of endothelium are guarded against, and in closure of the wounds the peritoneal edges are everted, both procedures lessening the possibility of post-operative adhesions. Mass ligatures are never used, which so often include nerve structure. Even the smallest bleeding vessels are ligatured. Any accumulation of blood, even

though sterile, interferes with wound healing. Our preference for skin closure after using figure of eight silk worm gut sutures to occlude dead spaces has been the Richter skin clips.

The restoration of tissues to as near normal as possible means as a rule a minimum amount of post-operative treatment, which is directed mainly to making patients comfortable during their stay in bed. Limbs and back are rubbed with oils and alcohol, light massage is given, passive exercise instituted, and bandages are kept snug. Much discomfort often arises from too tight binders, adhesive plasters, or stitches and complaints regarding these are given immediate attention. In general patients are allowed to get well without bothering them with unnecessary attention, which has a tendency to make them feel all is not as it should be. We find that a careful, well trained nurse conduces most to a patient's welfare in the first few days after operation. The many little things she does for comfort and reassurance are most valuable factors toward recovery.

Returned to bed all patients are placed in the Fowler position and so maintained until they are free from the effects of the ether. This is done that there may be no diaphragmatic compression with lessened lung expansion and increased liability to pneumonia. Peritonitis cases are kept in the Fowler position several days.

Severe nausea and vomiting after operations is encountered but little with the present drop method of anesthesia. If they be present, gastric lavage is really the only valuable treatment. Drugs by mouth are not given, nor is cold water. This latter not only does not help nausea, but is likely to induce gas pains, that source of suffering when once present, is so hard to alleviate.

The Murphy proctoclysis is instituted in all abdominal sections and other operations of severity. This method of fluid introduction into the blood through

the bowel restores blood pressure, aids in quieting thirst, and stimulates the kidney secretions.

Early bowel movements are conducive to a patient's well being and these are invited usually on the second day by enema or some easy laxative. Gas pains and meteorisms are infrequently present, but when so the passage of the flatus has been induced by the Fowler position, use of the rectal tube, enemas of various types, and heat to the abdomen.

Little concern is felt if the patient does not urinate within twelve or sixteen hours, though this rarely occurs when the "Murphy drip" is carried out. After this time, rather than inserting a catheter, which so often leads to cystitis, the patient is permitted to sit up in bed, or often lifted to a com-

mode, which procedure usually permits voluntary urination.

The pain of the first few hours, which is rarely severe, is eased by codeine used hypodermatically. Food, as albumen water and broths, is allowed on the second day. After the bowels are open, the diet is increased until by the fifth or sixth day the patient is on a general diet.

Laparotomy cases are kept in bed from ten days to two weeks. Perineal repairs remain recumbent several days longer. Nervously worn-out women remain in bed a longer period as circumstances permit, as rest is sometimes of equal value with the operation. During the period of stay in bed patients are permitted to turn from side to side as they desire.

San Marcos Block, Santa Barbara.

VISCEROPTOSIS IN WOMEN.*

BY DR. BELLE WOOD-COMSTOCK, GLENDALE SANITARIUM, GLENDALE, CAL.

It is not my desire tonight to present a complete or exhaustive paper on this subject, but to speak of it for a few moments in its relation to a symptom complex most familiar to us all, bringing out, perhaps, some points in the etiology and treatment not seemingly given much weight to in the general consideration of the condition.

Visceroptosis is essentially a women's disease. While occasionally in a certain type of man or in those who have in a short period of time lost a great deal of fat, we may find the stomach of the fish-hook type, the greater curvature below the umbilicus, with a corresponding drop in the transverse colon, we seldom find the extreme degree of ptosis of the stomach, the horseshoe colon with its acute angulation, that is so constantly found in a large majority of the women we have to treat, those only being exempt, apparently, who are so fat that no amount of muscular

weakness could result in prolapsed organs, simply because there is no space below into which they might fall.

Visceroptosis is so constant a finding in sick women, with its associated symptom complex, that in most cases we have only to hear the patient's story of her ills in order to know what physical examination or X-ray picture will reveal.

This sick woman who so frequently comes to us, whether or not she has lacerated perineum or cervix, uterine misplacement or cystic ovaries, has almost invariably the following category of symptoms: She is nervous, depressed, often hysterical, suffers from headache, insomnia; she is constipated, has indigestion, flatulence, bilious attacks, and perhaps mucous colic. There are often abdominal pains which may have been ascribed to a floating kidney, or for which the appendix has already been removed. To these may be added

*Read before the Los Angeles Obstetrical Society, January 11, 1916.

indefinite pains in various parts of the body—a frequent seat being the back of the neck—vasomotor disturbances, as cold hands or feet, low blood pressure, palpitation of the heart, and other symptoms usually classed as neurasthenic. Examination shows skin sallow, tongue coated, musculature atonic, chest negative, abdomen flaccid, or scaphoid in absence of abdominal fat, colon tender, cecum enlarged and palpable, sigmoid spastic. Bismuth meal shows an elongated stomach, three to six fingers below umbilicus, emptying itself slowly, the cecum dilated, colon extremely angulated, transverse colon often in the pelvis instead of in its normal position about the navel.

Coincident with the stasis and dilation of the cecum, we often find ileocecal incompetency, with its accompanying indicanuria. Our patient in the erect position shows a tendency to flat chest with prominent clavicles, prominent pouching abdominal wall, and straight spinal column; chest expansion is poor, the line of expansion being largely through the upper chest. Her whole posture indicates muscular weakness with its attendant lack of poise and proper muscle control.

This woman barely ekes out a physical existence; her nerves are on the "ragged edge;" she is tired every morning, with a constant dragged-out feeling; she is irritable, scolds her children, nags her husband, worries needlessly, making life miserable for herself and for those around her.

The part that Visceroptosis plays in this picture is so generally recognized that many of these women have at one time or another had treatment directed toward the correction of this condition, and hygienic corsets and abdominal supporters of some kind or another are widely advertised.

Etiology of Visceroptosis.

Frequency.—Nearly all clinicians agree as to the much greater frequency

of visceroptosis in women than in men. Quoting from Osler, "The records of the Johns Hopkins Hospital for the past few years show that one out of five women had movable kidney, and one out of every fifty men. In Emhorn's practice, ptosis of the abdominal viscera are met with in 6.5 per cent of the males and 33.24 per cent of the females. Smith believes that the majority of patients coming to the gynecologist have splanchnoptosis."

In looking over the records of 460 women, my own personal cases, I find 62 per cent of these to have some form of organic ptosis. This I believe to be a conservative estimate. While, of course, the fact that a large percentage of these cases have come for treatment for some chronic condition would make the percentage high, Roentgenological examination of these have never failed to show the typical prolapsed stomach and colon. While out of 75 consecutive cases of men examined by the X-ray, 95 per cent have shown the stomach and colon in a practically normal position, 95 per cent of the same number of women have shown these organs in a state of prolapsus.

Causative factors in this condition may be enumerated as:

First: Heredity—a certain body type, with its general inherited weakness.

Second: Rapid decrease in abdominal fat.

Third: Pregnancy and parturition, with its resultant sagging of the abdominal wall and change in shape of the abdominal cavity.

Fourth: Lack of proper muscle control, due to muscular weakness, not only of the abdominal muscles, themselves, but of the gluteal muscles and muscles of the back, the normal tonicity of which keep the body in proper poise.

It is to the last factor I wish particularly to call your attention tonight, believing that if we recognize its importance and direct our treatment, both

prophylactic and curative, along this line, our results will be much more to our satisfaction than perhaps they have been in the past.

The organs of the abdominal cavity are held in place normally by:

- (1) Ligaments,
- (2) Pressure of other abdominal organs,
- (3) Supporting power of the abdominal muscles.

The ligaments normally are not suspensory ligaments, but simply act as guy-ropes, each organ being capable of a slight degree of movement. Change in size, shape, or position of one organ affects the position of those organs next to it, but all abdominal organs are dependent primarily for their support upon the integrity of the abdominal muscles. It is impossible for any artificial abdominal supporter to hold the viscera in better position than this natural supporter, providing the body line is normal. Any sagging of the abdominal muscle will cause a corresponding drop in the viscera normally supported by them. But not only must the strength of the abdominal muscles be unimpaired, but there must be no interference with the shape of the abdominal cavity and with the anterior abdominal line. This depends not only upon the strength of the abdominal muscles, but also upon the tonicity and strength of the muscles that normally hold the body in proper poise.

If the gluteal muscles and the erector spinae are weak, we find, because of their chronic relaxation, a long line between the posterior infracostal border and the iliac crest, producing the straight back instead of the graceful curve denoting strength. Anteriorly the costal margin approximates the iliac crest, the abdominal wall becomes convex instead of straight, the greatest diameters being below the waist line instead of above. Associated with this a vitiated method of respiration with inadequate expansion at the lower

thoracic line produces a combination of forces, making it impossible for the viscera to remain in that part of the abdominal cavity where they would normally be if they had ample room above and proper support below.

So it can readily be seen that the supporting power of the abdominal muscles depends not only upon their own strength, but also upon their relation to the outline of the abdominal cavity as determined by the tonicity of the muscles of the back. If the correct relationship between these two great sets of muscles be not maintained, descent of the organs is inevitable.

Ptosis means interference with function, means stasis, constipation, with its attendant ills; the constipation, in turn, increasing the prolapsus; then follows absorption of toxins and auto-intoxication, with its resulting lowered nerve-tone, vaso-motor disturbances, general asthenia—this condition increasing the muscular weakness, both in skeletal and non-striped muscle—thereby establishing a vicious circle.

It is plain to be seen why women rather than men are the sufferers from this condition. From the time of puberty, the normal body line is interfered with by their method of dress, the breathing becomes thoracic, the abdominal muscles as well as the muscles of the back are trained to lean upon artificial supports. The more or less sedentary lives led by many of these women serves to increase the condition of atonicity and general muscular asthenia.

When the extra strain of child-bearing comes, the muscles are often unequal to their task, and during the puerperium are unable to regain even their former amount of tone, so we have another factor in the increase of organic ptosis.

So we may say that muscular asthenia lies as the basic cause for all cases of visceroptosis, whether inherited or acquired, and who is to say that the

frequency of the habitus enteropticus may not, to some extent, be due to the fact that women have for centuries lived and dressed in such a way as to cultivate this type, and to bequeath it to their posterity.

Great stress is laid by some on the importance of an insufficient amount of abdominal fat as a factor in producing splanchnoptosis. This, indeed, should not be ignored, especially in considering the treatment, but might not as much importance be attached to the muscular weakness attendant upon the loss in adipose tissue and to the general muscular strength coincident with a line of treatment directed toward increasing the general state of nutrition, as upon the mere question of filling up space in the abdominal cavity, which perhaps should be lessened by a normal contraction of the muscles designed to hold its contents in their proper position?

Treatment.

Because of the neurasthenic state into which these women have fallen, it is often wise to remove them from home and its responsibilities, and put them on a more or less modified rest cure. Intestinal putrefaction and auto-intoxication must be overcome by special attention to the ever-present constipation.

The treatment for the intestinal stasis must of necessity be symptomatic at first, as it is impossible to correct the sluggishness of the bowel until the basic local and general neuro-muscular tone be increased. The treatment for the constipation will depend upon whether or not we have a flaccid or spastic condition to deal with, but will include dietetic treatment, necessary laxatives, colonic flushings, and perhaps sinusoidal to the colon, abdominal massage, etc. If a spastic constipation or a colitis exists, the abdominal massage should be avoided, a bland diet should be given, oil and flaxseed enemas, perhaps Russian oil by mouth, fomenta-

tions or stupes to the abdomen, with the moist abdominal bandage.

The intestinal putrefaction may be checked to some extent by the use of enemas containing lemon juice or a solution of the bacillus *Bulgaricus*. Proper attention should be given the diet, with the thought of increasing the weight and general nutrition. To accomplish this, a diet comparatively rich in protein, with plenty of vitamin foods, such as green vegetables, etc., must be supplied.

Nervousness may be controlled by neutral baths, fomentations to the spine, gentle massage, and necessary bromides. The efficiency of the treatment will be increased if we plan for our patient a goodly amount of fresh air and sunshine, as much of the rest in bed as possible being taken out of doors. The time spent in bed will vary, depending on conditions. Often good results will be obtained with the patient up and about much of the time; or an hour's rest after meals may seem advisable. Those with greatly depleted nerve tone may make more rapid progress if on the complete rest cure for a few weeks.

It is needless to say that any condition demanding surgical treatment should not be overlooked. But with all of this, the importance of toning up the entire muscular system should not be forgotten. Muscular inertia being such a potent factor in the etiology of splanchnoptosis, any treatment which does not look toward correcting this basic condition must necessarily be inadequate. The rest cure, while beneficial to the patient's exhausted nervous system, but increases the muscular inactivity, and much better results may be obtained if, while on this rest cure, our patient has regular periods of exercise or muscle training, this work being supervised at first, if possible, by an attendant. It should include breathing exercises, with the thought of increasing the expansion of the lower thorax and increasing the development at the

waist line, in order to lengthen the transverse diameters of the upper abdominal cavity.

Simple but effective exercises may be given to increase the strength of the abdominal muscles, and it is of especial importance that work be given to increase the tonicity and strength of the back muscles. Exercises that will do this will also act upon the muscles of the abdominal wall, strengthening them and changing their relation to the organs they were designed to support.

The effect upon the general muscular system is of great importance, for always we find as a part of the vicious circle a general condition of low muscle tone which serves to accentuate the atonicity of the muscles especially concerned in the abdominal prolapsus. The first exercises may be given with the patient lying, then sitting, and then standing. Training should be given in correct posture and body poise, which will bring up the chest and to a great extent correct the tendency of the abdominal wall to pouch forward. The graduated nutritive series of Manual Swedish Movements includes exercises that will systematically develop the entire muscular system as well as the muscles of the trunk. Active exercise out of doors as soon as our patient is able, will be of great help in overcoming the general asthenia, at once a cause and a result of visceroptosis.

All these will greatly add to the general muscle tone, and soon we will see the results in a gradual disappearance of disagreeable symptoms, better circulation, better appetite, increased bowel activity, and a marked decrease in the amount of ptosis. It is plain to be seen that, in order for the best results to be obtained, our patient must be instructed as to a correct method of dressing. There must be no bands at the waist-line to interfere with proper development and the normal expansion at the base of the thorax of three or four inches. As soon as possible the splints

to which the muscles have for so long become accustomed and to which they owe so much of their weakness and inactivity, should be removed. It will often be necessary for an abdominal supporter to be worn for a time, but the muscles may soon be trained to independence if we can elicit the enthusiasm and cooperation of our patient.

There are many degrees and grades of visceroptosis, and its associated symptoms, and many a woman must be treated in her home instead of carrying out the ideal plan of spending some time in an institution. But if her home cares are not too many, we may often find it possible to help her to carry out a modification of this plan at home. She can be instructed as to dietetic habits, care of the bowels, necessary rest, correct dress, and given a few simple exercises to carry out systematically every day, which will bring results if persisted in.

I have for six years been treating women along these lines, both in an institution and in their homes, and I must say that the results have been most satisfactory whenever the treatment has been persisted in for a reasonable length of time.

Our women need physical training; they need re-education. Growing girls and the mothers of these girls need to be taught the harm to women-kind and through them to man-kind, of certain conventions in the way of dress. They need to be made to see that the beautiful body is the strong, healthy, well-poised body, whose muscles are left free to develop along natural lines, unhampered by artificial stays and supports, waist-lines and skirt-bands. Parents need to be made to see the importance of early physical training for girls, especially those who are born with a weak type of body line, that they may overcome this condition and avoid the results in visceroptosis and its associated ills at an early age. Women need to know that it is possi-

ble for them to be strong; that they were not made to be the mothers of the race and then cursed so that to be efficient in this great work would be impossible.

I do not know why physicians should not be the ones to emphasize this needed instruction. Perhaps we feel that the attempt would be useless; perhaps often it would be, but might not medicine reach its highest art in an effort to emancipate woman from the thralldom of a convention that lies at the foundation of many of her ills, destroys her beauty, lessens her efficiency, weakens her posterity, increases the burdens of the gynecologist, fills the pockets of the chiropractor and the quack, swells the records of divorce courts, and makes many a woman a burden to herself and

to her family, rather than the strength and inspiration to her husband, her children, and her friends that it is her right, her privilege and her happiness to be?

Summary.

1. Woman's life and habits tend to produce a muscular weariness of which visceroptosis is a frequent result.
2. In the treatment of the condition, muscle training should be constant, in order to correct the basic etiological factor.
3. Definite and united effort should be made to educate women, if possible, away from conventional habits of dress and muscular inactivity, and interest them in their need of physical training and general muscular development.

THE TREATMENT OF ABORTION.*

BY DR. WILLIAM H. GILBERT, LOS ANGELES.

Let me assume for the purpose of eliminating useless discussion, that practically all abortions are incomplete.

While it is true that possibly there are a few cases of complete abortion in the spontaneous or therapeutic class, nevertheless it is in the incomplete cases that ninety-eight per cent of all sepsis, mortality and morbidity exists. As a consequence it would be folly and a waste of time for us to consider from a treatment standpoint, the few cases that come under the head of primary complete abortion.

It is among the vast number of incomplete abortions wherein has arisen the much discussed various methods of treatment. Those of you who have practiced in this field for twenty years have heard this subject discussed so often that I feel as if I owe you an apology for its introduction. Nevertheless the subject is one so rife with speculation and its solution so far from being settled that I feel its discussion

by this Society would be to our mutual advantage.

Especially is this true since Montgomery read his history-making paper upon this subject at the San Francisco meeting of the A. M. A. Montgomery is not a pioneer in the let-alone or watchful-waiting line of treatment. For many years, men of standing in the profession have advocated the same thing. It is in all probability the swing of the pendulum the other way. In other words, the revulsion of opinion against the use of the curette in the removal of an incomplete abortion.

I will not discuss to any great extent therapeutic abortion, because no such percentage of evil results follow as does after criminal or sponeous abortion. In looking over one's case-book, it is surprising to learn how large a proportion of gynecologic cases can be traced to an abortion or a series of abortions.

A history of spontaneous cases will

*Read before the Los Angeles Obstetrical Society, January 11, 1916.

generally tell a story of infection of some sort, as a predisposing cause. Endoervicitis, endometritis, or some disease of the adnexa. Most of these conditions are due to a prolonged or neglected abortion. The initial abortion many times being criminal, and as a consequence of neglect, the long train of conditions just enumerated ensue; this producing an endless chain or as commonly known—the abortion habit.

Of course you have all seen the syphilitic who chronically aborts, but many who have the habit can be traced to an old neglected, incomplete abortion and its sequelae.

Without doubt most of the complications and sequelae of abortion can be traced to its etiology. For instance, if it is criminal, by the chance for infection and trauma, and if it is spontaneous, by the underlying, general or local conditions, such as syphilis or an incarcerated retroverted uterus.

Other factors in the causation of complications are its incompleteness; portions of the ovum remaining as a foreign body, and a culture medium. The length of time it continues, secrecy, and the desire to hide evidence of criminality and the assumption of household duties while the abortion is still incomplete. All of these are strong factors in producing complications which lead to mortality and morbidity.

One is struck by the difference between therapeutic, criminal and spontaneous abortion. How many of you have produced a therapeutic abortion and lost your case from sepsis. I venture to say, not one. Does it not seem strange that an abortion produced upon a patient suffering from heart, kidney or lung disease, almost invariably goes through it with good results locally and an improvement in the lesions of the other organs? On the other hand, a young woman in the flush of health rapidly succumbs to sepsis or if she recovers, has some or many of the various pelvic inflammations.

Therapeutic abortion is produced and the uterus emptied under the strictest of aseptic precautions. What happens in the spontaneous, or criminal abortion? The answer is too well known for me to dwell upon it. Some of you may rightly say there is not the opportunity for infection in therapeutic abortion that there is in criminal or spontaneous abortion. This is true, but remember that in criminal abortion the opportunity for infection is not only one of its inception, but also of its neglect, which is not true of therapeutic abortion. It is also true in spontaneous abortion that is complete. The recovery is rapid, and practically without mortality or morbidity. From these well established clinical facts it would seem that the mortality or morbidity of abortion depends upon, first, the method and means used in its production; second, its incompleteness; third, its neglect, and last the length of time the products of conception remain in the uterus. In looking over the etiology, pathology, and the clinical picture of the two types of abortion with the difference in mortality and morbidity, it ought not to be hard for us to decide as to which is the best line of treatment. This all looks very well upon paper, but believe me the stage of abortion is not set to our own liking, nor is the curtain rung up at the opportune moment for us to take our cue and become the principal actor in the tragedy which is about to be enacted. The uterus, contrary to old belief that it will always empty itself, has not done so. The time is not opportune for the separation of uterus and placenta. As a consequence, more or less placental tissue remains within the cavity of the uterus; here, it acts as a foreign body, and favors the development of any infection that has, or may be introduced by the patient, nurse or doctor. In the meanwhile bleeding has started, which necessitates attention on the part of the patient that eventually leads to infection. Perhaps the mo-

ment is opportune to point out that very few cases die of hemorrhage—practically all the mortality or morbidity is due to infection. There is no mortality or morbidity, where there is no infection. The uterus after abortion involutes less rapidly than at term. If the uterus is not empty, hemorrhage results with local anemia, and subinvolution accompanied by a deciduitis, which is an inducement for subsequent abortion. Incompleteness and infection is the pathological history of abortion. The infection may be the result of the production of an unclean abortion, or the unclean management of an incomplete abortion. Whatever course is pursued, the end result is the same. Uterine trauma occasionally occurs, and adds to the gravity of the situation. The uterus being more or less filled with a partially alive, partially dead, often gangrenous, stuffing and stinking mass, which is sufficiently loosened to permit hemorrhage, results in a condition of *locus minoris resistentia*. Soon follows the chill, elevation of temperature, leukocytosis with infiltration and exudates in the uterus and perimetrium. A bacteriologic examination of the products of gestation within the uterus will show an infection varying in virulence from saprophites to streptococci; in fact, Zangmeister has made extensive bacteriologic investigations of the subject and believes that eighty-six per cent of all post-abortive and puerperal infections are due to streptococci. Undoubtedly the presence of the ovum stimulates the uterus to contract, and until it empties itself keeps the lymphatics and vessels open, which soon become plugged with thrombi. As a result a local protective process is started which throws a leucocyte wall around the infected area. It is upon this localized walling off process and the establishment of immunity that the watchful waiting line of treatment has been founded. For the purpose of simplifying matters let us divide abortion into

two classes, the infected and uninfected. I hardly think that any of us believe that under proper precautions a non-infected uterus cannot be emptied with safety, and if the evacuation is complete the patient's convalescence will be rapid and uneventful. If this is true, which it certainly is, the time for operative interference is before infection takes place. There seems to be no diversity of opinion as to the safety of this procedure and when abortion is inevitable it should be done at the very earliest possible moment. If it were possible for us to see all cases of abortion in the pre-infected stage, this dreadful moral and physical scourge would be robbed of its terrors. Unfortunately a very small proportion of these cases come to us before at least a mild degree of infection had set in.

It is at this moment that the diversity of opinion has arisen as to its proper and safe treatment. Let us consider what has been said by many eminent men as to what they consider the safest and sanest course to pursue. Fellner believes in non-interference except when detained tissues cause severe intoxication. Findley believes it is better to encourage spontaneous evacuation by the use of ergot; failing in this he cures—the finger preferred. Mayer removes the placenta with the least possible injury to the uterus, and prefers the finger as a means of removal. Zangmeister leaves retained tissues for nature to remove, but if abscess forms, he opens them when pointing occurs. Watkins of Chicago believes the retained products of conception should be left to escape spontaneously and that the vigorous operative treatment so often used is more dangerous than the disease. He also advises not to explore or empty the uterus, except for hemorrhage, and takes the stand that there is no evidence to show that infected tissue increases virulence or growth of dangerous bacteria. He also believes, and is supported by De Lee of Chicago,

and Baldy of Philadelphia, that curetting with the finger or instrument produces raw surfaces, scattering the infection by dislodging septic material, thus producing embolic infections, and pelvic inflammatory exudates.

At a meeting of the Chicago Medical Society, held a little over a year ago, it went on record as saying that infected placental remains should be removed. Dr. Ross McPherson, attending surgeon New York Lying-In Hospital, gives the following technic as used in thirty-five hundred cases with a mortality of two and nine-tenths per cent. "When a physician decides that abortion is inevitable, let him proceed to pack the uterus with one-fourth inch strips of iodoform gauze. If a clot, or the fetus, or the placenta is within the grasp of the cervix and ready to be expelled, it is extracted with the sponge holder or forceps. After packing twenty-four hours, every patient should be prepared for a curettage, since no matter how complete the expulsion may appear to be, the curettement brings on bits of tissue liable, if not removed, to adhere to the uterine wall; if the cervix is not sufficiently dilated, this is accomplished with a Goodel dilator, and the uterine interior is explored with a sponge forceps for the purpose of extracting any large masses within its grasp. Careful curetting with a **large, sharp curette**, is then performed until the uterine cavity is perfectly clean. The entire cavity is then wiped out, first with dry gauze, and then with tincture of iodine and an iodoform gauze drain reaching to the fundus inserted. If obstinate hemorrhage persists the uterus may be packed." Probably this treatment as laid down by Dr. McPherson represents that most largely used by American physicians today. Last June in San Francisco, at the meeting of the A. M. A., Dr. E. E. Montgomery, professor of gynecology in Jefferson Medical College, said: "When it becomes evident that abortion will occur in

spite of measures to avoid it, the early aseptic evacuation of the uterus is advisable. The natural inclination of the physician when consulted by a patient who has undergone a recent abortion is to make sure that the embryonic products have been completely evacuated, particularly if there are present symptoms of infection, as indicated by elevation of temperature, rapid pulse, tenderness over the abdomen, and pain in pelvis. The friends of the patient attribute such symptoms to retention of portions of the product of gestation, and insist on measures of removal. If the symptoms are not better, they believe that the procedure has been incomplete and many times secure another physician to repeat the process. No plan of treatment could be more detrimental to the interests of the patient. Nature has arranged her forces to expel the uterine contents when they have completed their function, or when they are no longer in condition to continue it. In addition she affords ample protection against infection, unless her barriers are injudiciously broken down. Every examination should be made under strict aseptic precautions, and when these conditions are difficult to obtain the vulva should be kept covered with napkins rung out of a mixture of alcohol and water while pituitary extract should be administered hypodermically to promote expulsion of contents and closure of vessels." In the discussion that followed Dr. Albert Spaulding of San Francisco said: "There has been for some time a growing tendency among gynecologists and men of experience to present to the profession the idea that the surgical emptying of the uterus is bad in principle, and bad in practice. I am not one who agrees with this statement; there is undoubtedly a difference between the infected and uninfected patient following abortion; but in either case it has been my practice and that of Dr. Summers, who has preceded me in the women's clinic in

the Stanford University, to dilate and curette the uterus immediately after the patient enters the hospital. I do not know what Dr. Summers' results have been, but I do know my experience. In the last three years we have had eighty-six patients enter with symptoms of incomplete abortion, all with the exception of one were treated surgically. One was not treated, three were treated by manuel curettement of the uterus, and the other eighty-two with dilatation and curettage. Of these eighty-six patients, only one died. I present these statistics to show that patients can be well treated by cleaning out the uterus promptly. At the same time I am sure Dr. Montgomery can in general practice show that many patients can empty the uterus spontaneously, and are better untampered with. I wish to point out, however, that at present I cannot see the reason for not emptying the uterus in abortion." Dr. John Osborne Polok of Brooklyn, answering, said: "We divide abortion into the infected and non-infected cases. I know that the infected case which has protected itself as each infected case does protect itself, by a leucocytic wall, and if a placenta is present, and thrombi are formed in the vessels in the placenta site, that the infection is spread and the patient's condition is jeopardized by the routine procedure of curettage. The question of operative interference in abortion is this: Is there hemorrhage, or is there not hemorrhage? If there is no hemorrhage, our experience has been, even when the temperature is 104 or 105, that these patients, if placed in the Fowler position, with an ice pack put over the abdomen and elimination maintained with saline solution with intestinal rest, with no cathartics and with no food, show, inside of twenty-four to seventy-two hours, great improvement; the products will separate because they have been starved off by the formation of round cell deposits, and the products

of conception will be delivered completely, if let alone, in the large majority of cases. If it is not delivered spontaneously it is found with the uterus contracted, and this large mass lying in the dilated lower segment of the uterus." Dr. C. Lester Hall of Kansas City, Mo., in the discussion said: "He believed it would be justifiable in almost any case if the surgeon was perfectly clean to empty the uterus with a blunt instrument; to swab out the uterus once, and never again. It is the continual meddling that brings dire results, and even with all our care it is liable to produce septic results." This is, I believe, an up-to-the-minute summary of the concensus of opinion on the treatment of abortion. In selecting a treatment it certainly seems as if one is closing his eyes and making a stab in the dark, but out of all the pros and cons is gradually evolving a better understanding of the pathology of abortion, or shall I say a better understanding of the physiology of labor in abortion. Unlike labor at term, the uterus in abortion does not empty itself in a few hours; it takes days, sometimes weeks for the uterus by purely physiological processes to empty itself. The formation of the leucocyte wall around the placental site, and the consequent starving of the products of conception along with the infection is purely a physiologic effort of nature and not pathology. With this understanding we are gradually commencing to see the dawn of a new day and out of the chaos which has existed will come an order of proceedings which shall take the treatment of abortion out of the realms of uncertainty.

In conclusion I believe the following deductions represent my own personal views at the present time as to how I treat the various phases of abortion:

First: Threatened abortion should be treated by rest, and by removal of the offending cause. Whether it be syphilis, a lacerated cervix, or perineum,

endocervicitis, endometritis, ovarian or fibroid tumor, or an adherent retro-displaced uterus, the indications for its treatment or removal are the same.

Second: Therapeutic abortion is comparatively rare. When necessary, the patient should be anesthetised so as to best conserve the natural forces, and if possible the uterus be completely emptied at one sitting. Any patient whose condition is such that she cannot go to term, should be sterilized at this or some future time.

Third: When it comes to the treatment of inevitable abortion, whether it be produced or spontaneous, the personal equation, both as to the case itself and attendant plays an important role in its safe conduction.

There is no doubt in the minds of any of us that the curette has been productive of a vast amount of harm. It is a most valuable instrument in the hands of one skilled in its use, but a positive menace in the hands of one who has not had sufficient experience. I am satisfied the sharp curette has done more harm than good when placed in the hands of the profession in general. The use of the finger when dilatation will permit its easy introduction, is the best curette of all. Next to it I would place the blunt or wire curette. Preferable to all of these measures is the use of the placenta forcep. With a well locking and closely fitting pair of forceps one can easily remove the products of conception with the least possible amount of damage to the uterine wall, at the same time disturbing as little as possible the protective leucocyte wall nature has thrown around the embryonic site.

Personally I believe inevitable abortion is safer with the products of conception removed. I can conceive of no condition of inevitable abortion which is benefitted by allowing a gangrenous or stinking mass to remain within the cavity of the uterus. I can, however, understand how this condition can be

rendered infinitely more grave and the life of the patient placed in jeopardy by injudicious, poorly timed, and unskillful surgical meddling. I know of no condition, requiring what is often called minor surgery, that necessitates the use of so much good judgment as the selection of a surgical method for emptying the infected uterus. We have been told that saphrophitic infection is all that works upon the ovum. This is not true because many times the placenta is attached enough to keep parts of it alive. This being true, it forms a receptive host for the development of pathogenic bacteria.

We often hear it said that nature establishes immunity in these cases. While it is probably true this does occur, we all know that sometimes immunity is never established, or the patient dies from bacterial poisoning before immunity occurs. This being true, I believe it is better to empty the uterus, keeping in view all the time the idea of removing a foreign body other than the intention of doing a curettage. The walls of the uterus should be curetted as little as possible and the finger, forcep, or blunt curette always receiving preference over the sharp curette.

If one feels that his chances of injury are too great by this method he had better trust to the forces of nature for its expulsion.

I desire before closing to call attention to the use of pituitary extract in the treatment of abortion. By some this remedy has been designated the therapeutic curette for abortion as well as the medical forceps for labor. I am satisfied that in pituitrin we have a valuable adjunct. Up to the present time comparatively little has been done with it. Isolated cases of its use have been reported, but no long series of cases have been followed up. Personally I have only used it three times in the treatment of incomplete abortion. In this limited experience I am

impressed with it and for your benefit I will cite these cases.

Mrs. R., age 32, has had one child, still born. Had missed two periods and had had her "womb opened," as she expressed it, several days before calling me. She was suffering from severe pain and passing considerable blood with clots. Examination showed the vagina free, but the discharges had a decided putrefactive odor. The uterus was large, boggy, and the cervical canal undilated. Temp. was 100 degrees, pulse 102, she refused to be moved to a hospital and as she lived in an apartment house, I decided to try pituitrin. She was placed in the exaggerated Fowler position and given one cc. of P. D. & Co. pituitrin per hypo. Within an hour after its administration she emptied the uterus of its embryonic contents and went on to an uneventful recovery.

Case 2. Mrs. W. L., age 22, mother of one living child. Had missed three periods. I found her bleeding profusely, but no history of self induction. Had passed a fetus several hours before, but the placenta still remained. That morning I had operated a bad case of fulminating appendicitis and did not care to make an examination. One cc. of pituitrin was administered hypodermically. She was placed in a modified Fowler position and I saw her again in about three hours. The placenta was expelled and lay upon her napkin. She made a beautiful recovery, no examination had been or ever was made.

Case 3. Mrs. W. S., age 29, no previous pregnancy. Had missed three periods; had been flowing for two weeks; foetus expelled a week before. examination revealed the uterus about the size of an orange, with contracted cervical canal. Discharge offensive. Temp. 101°, pulse 98, with considerable pain and tenderness in pelvis. The question of operative interference was of doubtful justification in my mind, and I decided to try the "watchful

waiting" line of treatment plus the use of pituitrin. She was placed in the Fowler position. Hot moist bichloride packs applied to lower abdomen and vulva, and pituitrin administered. I saw her again that night and she had expelled a mass of foul smelling gangrenous and highly infected placenta. Her temperature the next morning was normal and she made a good recovery. While a few cases such as I have just cited don't prove anything, they do indicate that there is a field of usefulness in the treatment of incomplete abortion with pituitrin.

715-725 Baker-Detwiler Building.

Interol

The necessity for a thorough knowledge of the action of any therapeutic agent, before one can secure from it satisfactory results, is very strongly emphasized in the case of mineral oil. It is surprising sometimes to note the erroneous ideas and impressions that are held by both physicians and patients regarding it. One finds it to be often used as if it were a laxative or even cathartic agent. One hears of its being used to "clean out the bowel" and the complaint often made that mineral oil is too slow to act, or that doctor or patient cannot afford to wait for its action, shows how little its actual modus operandi is appreciated.

Mineral oil is a lubricant and nothing else; that is, if it be of proper purity to be put into an intestinal canal. Not every oil is "safe"; i. e., unless hyper-refined (which most oils are not) there may remain sulphur compounds or lighter hydrocarbons, which cause unpleasant symptoms such as nausea, eructations and flatulence—or do serious harm in the way of irritating the kidneys.

Dr. George W. Brown (oculist and aurist) has moved to 819 Hollingsworth Building, Sixth at Hill St.

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EDITORIAL

LIFE SUBSCRIBERS.

Those of our subscribers and friends who were invited to become life subscribers to the Southern California Practitioner for a nominal sum, to pay off the indebtedness incurred in opposing a federal suit that would make medical journalism unduly hazardous, will kindly send in their checks at once or notify us that they do not care to do the part assigned them. We will then extend the offer to others, since this is a debt that must be paid. So please attend to this at once.

STATE MEDICAL MEETING AT FRESNO.

It would be well for you to make your reservations at the Hotel Fresno now for the meeting of the California State Medical Association, April 18, 19 and 20, 1916. Fresno is fortunate in having a good hotel, as well as in being centrally located in the State. The roads at that time ought to be in good condition, and many will prefer the

auto to the train. The program is already full to overflowing, and we have no doubt Fresno will overflow with hospitality. This promises to be a very important meeting in many ways, and you owe it in justice to yourself, your profession and your patients, to attend. And don't fail to take at least some part in the meeting.

MALPRACTICE DEFENSE.

A large proportion of the dues exacted by the County Societies goes to the State Association for expenses incurred in defending members charged with malpractice. This is of doubtful value to many members, especially those who carry so-called malpractice defense in insurance companies. In such cases, the State Association demands that the accused member declare whether he shall be defended by the company in which he is insured or by the State Medical Association. Many of those in active practice carry so-called malpractice insurance and are

reluctant about relying exclusively upon the defense afforded by the State Association. When this is considered in connection with the fact that not all members are equally liable to such suits, it is evident that the State Medical Association defense against malpractice suits is not altogether desirable nor quite fair to many of the members. A further limitation is now imposed by the ruling of the House of Delegates of the State Medical Association, that it will not defend a suit for alleged malpractice which had its origin in an action to collect a bill, brought within one year from the time of termination of last service. Though the physician's accounts will not be outlawed through the statutes of limitations within a year, it is often necessary to begin legal action within much less than a year in order to realize upon an account against a debtor of doubtful financial stability. Wouldn't it be better and more just to do away altogether with malpractice defense through the State Medical Association?

WHY LOWER MEDICAL FEES?

At the 1914 meeting of the California State Medical Association, our State Association fell in line with those urging special low rates for medical and surgical treatment under the state compensation feature of the employers' liability act. A report of financial plethora is now made by the executives

in charge of the enforcement of this act, and it is proposed to return a certain percentage of the charges that have been made under the act. All of which would seem to serve as evidence that there was no actual extreme necessity for the physicians and surgeons to be called upon to do work for subnormal fees. If the medical and surgical fee bills recognized by our County and State medical organizations mean anything, they may surely be taken to indicate that the lower fees mentioned are to be regarded as the lowest for which good service can be rendered by physicians and surgeons without sacrifice. Why did our State Medical Association countenance subnormal fees in this special instance, practically making an exception of the cases treated under the employers' liability act? Isn't it just barely possible that the poor patients who pay their medical and surgical bills, are entitled to as low fees as the State or the employers paying for such services under this act, which covers services rendered many individuals receiving good salaries? Is the charging of subnormal medical and surgical fees to be regarded as ethical as a general principle when dealing with the poverty-stricken, or are such fees to apply only to such instances as may be indicated by our State Association under the guidance of astute politicians? Will our State Medical Association continue its endorsement of a double standard of fees? WHY?

BOOK REVIEWS

A TEXT-BOOK OF THE PRACTICE OF MEDICINE. By James M. Anders, M.D., Ph.D., LL.D., Professor of Medicine and Clinical Medicine, Medico-Chirurgical College, Philadelphia. Twelfth Edition Thoroughly Revised. Octavo of 1336 pages, fully illustrated. Philadelphia and London: W. B. Saunders Company, 1915. Cloth, \$5.50 net; Half Morocco, \$7.00 net.

The appearance of a twelfth edition attests the well deserved popularity of Anders' Practice. The new matter in

this edition embraces sections on Colon bacillus infections; Large-cell splenomegaly; Tuberculosis of the thyroid gland; Vagotomy and hypophyseal obesity. Among the important additions we note Role of the cockroach in the spread of cholera; the Glycyltryptophan reaction in cerebrospinal meningitis; Schick's test for antitoxin in the blood in diphtheria; Complement-devia-

tion test in pertussis; d'Espines sign in tuberculosis of the bronchial lymph glands; Phenolsulphenophthalein test in nephritis; Barany and Neumann's test in diagnosis of labyrinthine disease. It is a work well calculated to introduce the student to the present state of our knowledge of the practice of medicine in general and of the diagnosis, differential diagnosis, and treatment of disease in particular.

ANNUAL REPORT OF THE SURGEON-
General of the Public Health Service
of the United States for the Fiscal
Year 1915.

The investigations of the Division of Scientific Research have been classified and conducted under the following broad heads: (1) Diseases of man, including hookworm disease, malaria, pellagra, trachoma, typhoid fever, and tuberculosis; (2) industrial hygiene, including occupational diseases; (3) school hygiene; (4) mental hygiene; (5) rural sanitation; (6) sanitary organization and administration; (7) viruses, serums, toxins, and analogous products; (8) pollution of navigable waters; (9) surveys of costal waters, including shellfish areas; (10) treatment of industrial wastes; and (11) disposal of sewage.

THE MEDICAL CLINICS OF CHICAGO.
Volume I, Number III (November, 1915.)
Octavo of 200 pages, 23 illustrations.
Philadelphia and London: W. B. Saunders Company, 1915. Price per year:
Paper, \$8.00; Cloth, \$12.00.

The excellent opening article deals largely with the treatment of typhoid fever, and is presented by Dr. Charles Spencer Williamson. We most heartily agree with his recommendation regarding diet in typhoid. The starving of these patients is but a relic of barbarism. An adult may well receive 3,000 calories a day, in the form of milk, cream soups, eggs, the well cooked soft cereals, tapioca mixtures, wine jellies and such like. Many a

case will be all the better for the addition of tea and coffee to the diet.

The Medical Clinics of Chicago is quite a faithful portrayal of the medical clinics of Chicago.

BANDAGING. By A. D. Whiting, M.D., Instructor in Surgery at the University of Pennsylvania. 12mo of 151 pages, with 117 original illustrations. Philadelphia and London: W. B. Saunders Company, 1915. Cloth, \$1.25 net.

Though bandaging is not an exact science, this volume with its many excellent illustrations will do much to help a multitude of students and practitioners to become more adept in the art.

INTERNATIONAL CLINICS. Edited by Henry W. Cattell, A.M., M.D., Philadelphia. Volume IV. Twenty-fifth Series, 1915. Philadelphia and London: J. B. Lippincott Company.

You must read the opening article in this 25th Anniversary Number, by "William Osler," on The Coming of Age of Internal Medicine in America. Osler always says so much in small space and says it so well. In this issue there are several articles dealing with the progress made during the past quarter century. The editor discusses the announcement that the Public Health Service found Pelagra to be due to defective proteid diet, and would place this discovery with the recognition of the role played by the *Stegomyia* in yellow fever and the *Pediculus* in typhus fever, as the three epoch-making discoveries of the past quarter century.

NITRO BY HYPO. A Pep-tonized Tonic for the Physician. By Edwin P. Harworth, Superintendent of the Willows Maternity Sanitarium. Kansas City: The Willows Magazine Company. \$1.00.

This is a book for the doctor, himself, devoted especially to methods, business, inspiration and uplift, well calculated to cheer a depressed and dispirited practitioner on to greater study and more serious effort. The only book of its kind we know.

MISCELLANEOUS

DR. ROSE BULLARD.

Cause of Death.

By H. G. Brainerd, M.D., Los Angeles.

On the 16th of December last Dr. Rose Bullard returned to her home about noon after a long ride in the cold—within an hour she had a hard chill, followed by a temperature of 104, which subsided the following morning with marked sweating. About noon of the 17th she had another chill and again the temperature reached 104. At this time the urine was found by Dr. Zeiler to be smoky, scanty, sp. gr. 1028, a trace of albumen. Microscopic examination showed a few hyalin and granular casts and a large number of red blood cells. On the 18th she had a third chill, followed by a temperature again reaching 104, with sweating the following morning. A blood examination was then made by Dr. Zeiler and he reported that there was evidently a systemic infection, as the examination showed—

Leucocytes	14,000
Differential leucocyte count, 250 cells counted:—	
Polymorphonuclears	240—96. %
Large mononuclears 1.....	2— 0.8%
Transitionals 1.....	
Lymphocytes	8— 3.2%
	<hr/> 250—100.0%

The red blood cells were uniform in size, regular in shape and took the stain evenly. No nucleated red blood cells or blood parasites seen. No abnormal leucocytes seen.

On the 19th the urine was freer in quantity and the blood and casts had disappeared, and she seemed a little better, but there was a little rigidity and a little tenderness of the right lower quadrant of the abdomen and over the right kidney. She was examined by Drs. King and Alden, who decided that there was no appendicitis or salpingitis. On the 20th the abdomen became much distended and she was ex-

amined by Drs. Alden, King and M. L. Moore, who agreed that there was some abnormal condition in the abdomen, but of such obscure character as to render the diagnosis uncertain and they advised against operation. As she had had a sinus for many years in the upper first right molar, on the 21st a radiograph was taken by Dr. G. M. Crow, which showed a slight amount of pus at the root of the tooth, but as there had been no external evidence of activity in the recent past it was not believed that this could be the source of her infection. On the morning of the 22nd there was evidently accumulation of fluid in the lower right quadrant of the abdomen and it was determined that it was best to take her to the hospital and open the abdomen, especially as she herself said—“if you are to do anything for me why do you not do it at once.” She was taken to the California Hospital and at 11 a.m. December 22nd, by Drs. Alden, Morton and N. C. Dunsmoor operated under nitrous oxide and oxygen anaesthesia. The right iliac fossa was opened and drained. There was a turbid fluid in which floated flakes of pus. Death took place about nine hours after operation. An autopsy by Dr. Brem showed the following:

A general peritonitis. Pus in the retroperitoneal tissue. Liver, gall bladder, stomach, large and small intestines and appendix normal. Mesentric and retroperitoneal lymph nodes normal. Right ovary slightly cystic. Body of the uterus, tubes and left ovary absent. Spleen soft and from the pulp a haemolytic streptococcus was cultivated. Both plural cavities contained a small amount of thin pus. Slight congestion of both bases of the lungs. Pericardium and heart normal. Kidneys showed cloudy swelling. From a specimen of urine passed December 22nd and from the peritoneal pus obtained at operation and

from the spleen obtained at autopsy a haemolytic streptococcus was grown. No antrum of infection was found.

This was a most perplexing and puzzling case in which to make a diagnosis, and we suffered the distress of seeing a most useful and skillful life slip away while we were powerless to stay it.

THE HOT PACK IN THE CALIFORNIA HOSPITAL.

By Hon. Lee C. Gates, Los Angeles.

My education is more nearly complete than it was ten days ago. I have had a "hot pack!" To those who may not know what a hot pack is I would say that, after civilization had laid its restraining hand upon some of the savageries of the Inquisition the hot pack disappeared as one of the cruelties too fierce and vicious for civilized enjoyment. But, little by little, it has been revived and is now practiced by some of the fierce Bedouin tribes, the Apache Indians, and the California Hospital.

I am unaware as to the reason why the wild tribes of the desert use it, but conjecture that they conceive it to be the most effective form of terrorism yet conceived by their untutored minds and the fiercest form of revenge. But with the hospital it is different. There it is used as one of the highest and most dignified forms of the therapeutic art. If the patient is afflicted with a swagger and threatens to run away with superabundant vitality, the hot pack will reduce him to a dependent docility. If he manifests ennui or excessive fatigue, the hot pack opens his pores, stimulates cuticle exhalation and causes him to forget all but the hot pack and inspires him with new life, or a desire to die.

But if he shall come surcharged with accumulated toxins, the amassed poisons of ten or twelve years of association with law, society and theology, then indeed, the hot pack becomes the boon triumphant. One would think from the above that only in the latter

case is the hot pack a success, but not so. It is always a success. No patient after the first one ever proclaims it a failure, or asks for more. But let me describe it that you may fully grasp its merit:

Ingredients of the hot pack are hot water, hotter water, boiling water, boiled blankets, a rubber blanket, an ice pack for the head, a gallon of ice water, a siphon, hot water, hot water bottles, a dozen or more, a close, hot room, a salamander attendant, alcohol to revive, hot blankets and hot water, and well—perhaps, a little more hot water. The patient is most conveniently handled if he is in an unconscious state. Even if conscious at the beginning, he becomes insensible toward the close, or else absolutely uncontrollable. But given a patient in full possession of his faculties please note the procedure.

The bathtub is filled with water heated to a few degrees above the boiling point. Then the patient is instructed to wrap a sheet about his otherwise unprotected form and he is hurried into the tub. A few degrees of heat is then added to the water. If he manifests signs of interest by assaulting the attendant or leaping out the window, or perching upon the chandelier, it is considered that the preliminary steps of the proceeding are successful—otherwise, more heat is applied.

Next, the parboiled victim is conducted or conveyed to the adjoining chamber where the real and substantial virtues of the hot pack are made manifest. Here is a wide couch covered with a voluminous rubber blanket, which in turn is covered with a rough woollen blanket, dry but hot, which in turn is covered by several layers of like blankets just taken from the cauldrons in which they have been boiling for hours.

Upon this scalding, steaming couch the victim (for such I shall call him henceforth) is now laid, divested of all protection, save such fortitude as Nature may have bestowed, his body ex-

tended to its full length, his arms drawn down and secured to his sides. Then, instantly, there is pressed upon him another layer (or layers) of scalding blankets, heated many degrees beyond those upon which he reposes.

Now, all being ready, the attendant, with asbestos gloves, proceeds to lift the edges of all the layers above and below and enfolds them upon the now terror-stricken and parboiled victim. Then, still not content, the attendant piles high above all, the remaining bedding to be found in the room. The ice pack is adjusted to the victim's head, the siphon is given to his lips, and he proceeds to the task of perspiring an ounce or more per second, drinking an equal amount to prevent internal conflagration, and freezes his brain, meanwhile, to preserve a modicum of sanity.

"How long, oh Lord? How long?" gasps the victim, and "twenty minutes," answers the attendant. The victim begins to melt. He feels himself rapidly liquifying and gurgles, "How much longer?" to which the attendant, with a leisurely look at his watch, responds, "Only eighteen minutes."

The victim groans and begs for the siphon again. He feels the steam rise from the stream of water as it heats and finds it way along the digestive tract.

He feels that he is being consumed like the earth on that final day, with fervent heat. He knows that he is no longer solid, that he has been converted into rivulets and rills—that he is boating in a lake and no longer reclining upon a couch. He asks again, "How long yet?" and is told, "Only fifteen minutes more."

For a few minutes he is silent, save to ask again for water and to request that the icicle formed back of his ear be broken from the ice pack and applied to that portion of him now being consumed by fire, and he knows at last that he is fricasseed.

Then he begins to beg his tormentor

to shorten the time, but in vain. Then he implores him to lift the covers for a fraction of a second, that a breath of air might fan his perfervid frame. Then he supplicates that he may be privileged to raise only one hand to his throat that he may breathe more like a human being than a steam engine, but to all these a deaf ear is turned.

Then he turns his thoughts inward and imagines what he may have become, for by this time he knows he is no longer human. He thinks he may be a giant Roman candle or the crater of a volcano, but, finally, he settles down to the conviction that he is one of the perpetual geysers of the Yellowstone Park, and then, just as consciousness leaves him, he recognizes himself as the fountain of eternal life, or death, heated to the -uth degree.

But the twenty minutes are up. The steaming hot blankets are removed, the victim gives faint signs of life, returning animation is slowly becoming apparent and, finally, when it is certain that he can once more suffer he is again tightly wrapped in hot, dry blankets and told, as his tormentor departs, that he will return in an hour and take him out. At this time the unfortunate victim faints and Nature, kinder than man, draws her veil of pity and mercy across his tortured face and saves him from utter insanity and total despair.

At last the hour has passed, the torturer has returned, the cooling, refreshing air of Nature has fanned the fire and torture from his frame and brow, he repossesses his senses and swearing that perdition shall not again o'ertake him, he vows and vows and vows yet again that he will lead a different life, no matter what, and rather than the Hot Pack he will accept purgatory as a preferable place of refuge forever and ever, so long as life shall last for him.

Verily, verily I say unto you, fly unto all the evils you know not of, rather than endure the Hot Pack once!—The Graphic, Los Angeles, January 29, 1916.

SOUTHERN CALIFORNIA PRACTITIONER.

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SUBMUCOUS RESECTION OF THE NASAL SEPTUM.

BY C. G. STIVERS, M.D., SECRETARY EYE AND EAR SECTION, LOS ANGELES COUNTY MEDICAL ASSOCIATION.

Two great passageways traverse the naso-pharyngeal region, the breath road and the food road. Their occlusion is fatal and their obstruction in even a slight degree is seriously detrimental, such obstruction of one or the other constituting the common factor in many of the diseases we are called upon to treat. The normal course of the breath is through the nostrils, the mouth passageway being supplementary. Nasal respiration warms, moistens and filters the inspired air and solid particles carried in its current are caught by the hairs within the vestibule and entangled by the mucous bathing the irregular surfaces of the walls. If for any cause the nose is stopped, one breathes through the mouth, thus using the supplementary route and thus losing the warming, moistening and filtering of the air. This deficiency in the preparation of the inspired air before it goes to the lungs is the first evil in a long line of injurious effects dependent upon mouth breathing, if that substitution of the supplementary route in place of the nasal breath road becomes a permanent practice.

Anosmia, or loss of the sense of smell abolishes a group of physical gratifications which science is powerless to restore, and the conservation of the sense of smell, or its restoration by the operation of sub-mucous resection of the septum brings back these lost gratifications when there is no nerve degeneration. The pleasures of eating and drinking, aside from the mere allaying of hunger and thirst, depend mainly upon olfaction. The savor of meat and the bouquet of champagne are made known by minute particles borne upon the air and impinging upon the nerve terminals distributed over the septum and turbinals. If both the anterior and posterior nostrils are stopped up by a bent (deviated) septum, the finest flavored game tastes the same as dried beef, and champagne differs little from soda water plain. It has been proved that when eating is accompanied by pleasurable sensations that the stomach performs its functions much better than when the food is shoveled into it like so much coal into a furnace. The loss of the sense of smell then becomes an influential although often unnoted fac-

tor in the injury of digestion and the impairment of nutrition.

One of the most common causes of obstruction of nasal respiration is deviation of the septum, whereby the two parallel passageways of the nose are narrowed at any point by a bending of the partition, called the septum, between them.

Contributing secondary causes of obstruction are hypertrophies of the turbinate bones and hyperplasia of the mucous membrane covering the nasal passages. The septum is a partition formed by the perpendicular plate of the ethmoid bone above and the vomer below with the addition of the septal cartilage. In articulating with each other the two bones leave in the front of the nose a triangular space and this is filled by the triangular cartilage giving to the septum the shape of an unsymmetrical square plate with irregular margins and standing in a perpendicular position above the arch of the hard palate. On each side of the septum the periosteum is covered by a fine network of arteries, veins and nerves joined by connective tissue and overlaid by a stratified-ciliated epithelium, whose function should be preserved as in its upper part are distributed the terminal filaments of the nerves of the sense of smell. There are no muscles in the septum. There is a great deal of disagreement as to the causes of deviation of the septum. It was Trendelenburg who first associated it with high arch or Gothic palate; he did not deem it due to a lack of development of the maxillary bones. Loewy says that Gothic arch is due to rickets. Zucker-Kandl scouts this idea and says that he has been unable to associate rickets with deviated septa, as it is the lower and not the upper jaw which exhibits rachitic influence. Americans are more prone to this condition than Europeans. Talbot in an extensive investigation of facial, including nasal bones, concludes that deviated septa are due to trau-

matism, however slight, setting up a low grade of morbid action, hampering the normal function of the nose and leading to mouth breathing, flat, narrow arch, etc., also to an incomplete development of the adjacent bony parts, especially the turbinated bones influencing the vomer (ossification of which is not completed until after puberty) to adjust itself to compensate for the irregularities of the nasal passages, hence it and other structures of the septum are bent to one side or the other to allow for the greatest degree of use of the nasal passages. He believes there is a neurotic element at the bottom of the causes leading to an asymmetrical development of the facial bones. Ballenger sums up the causation as follows:

(a) Neuroses or stigmata of degeneration causing either an arrest or an excessive development of the bones of the face, including the nose, one of the expressions of the neuroses being deformed septa.

There is a general agreement that marked or harmful deviations of the septum are rarely congenital but very frequently developmental. In childhood the roof of the palate curves more sharply than in adult life and has been called the Gothic arch. This arch flattens with further development and in doing so usually gives room for the downward growth of the septum, but sometimes this flattening does not occur as is seen in cases of hypertrophic tonsils and adenoids with mouth breathing, in which the tongue is not pressed into the roof of the mouth as it should be, thereby losing its wedgelike effect on the sides of the upper jaw and thereby not flattening the arch; the septum continuing to grow is hindered below by the persistent Gothic arch and the immobile ethmoid bone at the base of the brain, and bending to one side or the other results. Traumatism accounts for many cases. During the process of learning to walk almost every child

falls more or less frequently on his nose and a greater or lesser degree of violence is exerted on the septum, and although it may not be actually broken yet the counter stroke produces a low grade of periosteal inflammation that leads to weakening of the septal structure.

The deviation may be at any point of the septum and include both bone and cartilage, it may be bent to one side or the other or occupy an S-shape position with occlusion of both nostrils. There is an important relation between septal deviation and catarrhal rhinitis, they have reciprocal causes—prolonged inflammation produces hypertrophy and deformities. On the other hand, structural changes by impeded respiration and by the harsh efforts patients make in picking, douching and blowing, to remove their discomfort bring about chronic inflammation. When the two conditions co-exist, as they usually do, we should first cure the rhinitis, and only when remedies faithfully applied fail to do so should other procedures be undertaken. In many cases after the patient has been cured of the rhinitis it has been found that all symptoms are so much better that it is not necessary to go further—but whatever be the cause of the deviation when it exists surgical procedures are almost without exception necessary to produce normal nasal respiration. In the technique both osteotomy and chondrotomy, either one or both in combination is used. It must be borne in mind that a septum operation should not lightly be undertaken, as in the healing of all bone injuries from six weeks to three months must be allowed for complete healing and entire absence of discomfort. However, the precise place and character of the operation having been determined (and in my hands, the sub-mucous resection of the septum having met the greatest number of indications) the patient should be prepared, first, by removing hypertrophied tonsils and ade-

noids, if present, and hypertrophied turbinal tissue which might impinge upon the septum when straightened, then after a suitable time has elapsed for thorough healing to take place the patient is ready for the submucous operation. The technique of the operation is as follows:

The nostrils thoroughly cleansed with an alkaline antiseptic solution and the patient placed in a suitable position, either the posterior recumbent posture on a table, or the upright posture in the office chair, whose back can be instantly lowered in case of threatened syncope. Local anesthesia is produced by applying on each side a solution of cocaine of from 1 to 4%, applied on pieces of gauze, packed thoroughly into the nasal fossa and allowed to remain ten minutes. This cocaine gauze packing may be repeated and left another ten minutes, then followed by the same packing with a solution of adrenalin 1 to 1000 and allowed to remain 5 minutes. The muco skin border where the first incision is made, should be desensitized by a hypodermic injection of novocain 1 to 3%, and adrenalin a solution 1 to 1000, 3 to 5 minutes. The packing is removed from the nose and a preliminary incision is left to the choice of the operator, who carefully separates the mucous membrane and perichondrium from the cartilage with elevators over the entire surface to be operated, then carries his incision through the cartilage to the opposite side, care being taken not to open through the mucous membrane and perichondrium into the opposite nostril. The lifting of the perichondrium and mucous membrane from the entire surface to be operated is then carried out as in the initial side, the cartilage so denuded at both sides is then removed by Ballenger's swivel-knife, bony deformities with Ballenger-Foster bone forceps, cup-shaped forceps, and maxillary crest, by Hurd's forceps or by the chisel and mallet. Hemorrhage is checked by

sponging, all spicules of bone and cartilage are wiped out and the edges of the first incision are brought together by one No. 2 iron-dyed black silk suture, using a full curved needle $\frac{1}{4}$ inch long and delicate forceps. The entire nasal space is then packed with gauze soaked in sterile vaseline in the following manner:

The first strip is applied over a strip of oiled silk against the site of the initial incision; this obviates sticking when removing. The subsequent gauze strips extending the length of the nasal passageway are superimposed on this initial piece, both nostrils being packed in the same manner. The patient is then instructed, if an office patient, to go to bed and remain quiet for 24 hours, with cold compresses over the nose, when he may visit the office and the packing will be removed in the reverse order from that in which it was placed in the nostrils. A hospital patient is much more satisfactory in every way as the responsibility for the care is transferred to the capable hospital management, and the danger of post-operative hemorrhage is practically done away with thereby. The packing should be removed after 24 hours from both nostrils, the nose irrigated with normal salt solution and a small amount of vaseline applied to the surfaces; no further packing is necessary, but it is wise to occlude the operated side with

a small pledget of cotton, the psychological effect of which will induce the patient to keep his fingers away from the nose. All stitches should be removed within 48 hours. If perforations occur during the operation they should be closed at once by fine catgut or silk sutures. The after treatment consists in patient douching the nose gently with some mild alkaline antiseptic solution and the application of a small amount of vaseline to secure moisture.

The benefit to the general health has been marked in many of my cases operated for correction of nasal obstruction. In many instances substantial gains in weight began at once upon the restoration of nasal breathing and restoration of the sense of smell and taste.

Chronic bronchitis dependent on mouth breathing is relieved at once, as is laryngitis, pharyngitis and tracheitis. The "acid mouth" of the dentist is often cured in this way.

Modern rhinologists do not sacrifice turbinate tissue, knowing that loss of function follows such removal.

The advantage of the sub-mucous resection lies in the fact that while removing the causes of nasal obstruction it does not cripple nasal function.

REFERENCES.

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 Gill, "The Nose, Throat and Ear."
 Gray, "Anatomy."
 502-3 Auditorium Bldg.

EXPERIENCES WITH PITUITRIN IN OBSTETRICS.*

BY F. O. YOST, M.D.

Introduction.—Pituitrin has proved itself such an effective eclolic agent that its use in labor has become very general.

It is probably true, as stated by Landis (Progressive Medicine, Dec., 1914), that it is being used by many practitioners as a routine measure in all

cases of labor, without due regard to its very definite dangers.

Partly on this account I have thought that a discussion by the members of the Los Angeles Obstetrical Society, in regard to its proper and improper use, would be of great value, as the comparison of the experiences of those quali-

*Read before the Los Angeles Obstetrical Society, December 14, 1915.

fied by special training and study, may bring out important truths concerning this comparatively new therapeutic agent.

Personally, I have made considerable use of pituitrin during the last three years, and have observed its effects on quite a variety of conditions.

While I have practically no ill effects to record, I find myself becoming more cautious in resorting to it than I at first was, and more impressed with the fact that in pituitrin the obstetrician has a tremendously powerful implement, and one with which he may do harm if he errs in judgment in regard to the desirability of its use in any given case.

Pituitrin has, I am very sure, greatly reduced the number of forceps deliveries in my practice, and probably in so doing has prevented some damage to both mothers and children which is inevitable in forceps work. But it has by no means entirely supplanted the use of instruments, and in some cases I believe is a more dangerous agent to resort to than is the forceps.

Method of Action of Pituitrin Extract.—Edgar's words sum up the method of its action particularly well. He says: "The drug apparently acts by collecting small non-effective contractions into larger and more effective ones. These contractions may last several minutes—ten, according to some—but it is denied by observers that the drug ever causes continuous tetanic contractions of the uterus (tetanus uteri), even when given in maximum doses.

"While theoretically pituitary extract causes intermittent contractions of the uterus, in practice when full or repeated doses have been given and too great resistance to delivery exists, these contractions approach to the continuous in character, and clinically must so be reckoned with."

Everyone who has used the remedy to any extent seems convinced that pituitrin has an important place in ob-

stetrics and that it has certainly come to stay. So our problem is to consider how and when it is proper to use it in our practice, and to determine under what circumstances it is ineffective or dangerous.

I will therefore briefly state some of my experiences with it in various conditions and trust that others will enlarge the matter by giving their experiences also.

The Use of Pituitary Extract to Induce Labor.

This is a phase of the subject of which I can say little as I have not employed it frequently for this purpose. In primiparae with firm and undilated cervixes I would consider pituitrin at this stage contraindicated. Bandler, however, advocates its use in multiparae where the head is well engaged and the presentation normal and some uterine irritability present. I have used it a few times in such cases and will give the following as an example of the type:

Case I. Multipara. Time fixed for labor about up. Sent for me in the evening thinking herself in labor. Examination shows a patulous dilatable cervix and irregular cramp like "false" pains. I watched her for a couple of hours, but no progress was made and the pains died away. This was repeated again, in a few days, and a third time in about a week. But on this third occasion I tried Bandler's idea and gave a dose of pituitrin after making preparations for delivery. The pituitrin worked like a charm and rendered the "false" pains regular and effective so that in about four hours the child was normally delivered.

In such cases the dose should not be too large, so as to avoid too violent and prolonged contractions which might cause asphyxia or premature separation of the placenta. Half an ampoule is enough, but this may be repeated at hourly intervals if needed.

(Continued on page 64.)

THE SOUTHERN CA

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The DIAC
INTERNAL SECF

Prepared by Henry R. Harrov

THIS SERIES will constitute a compendium of information on the detection of early and late, functional and organic, disease of the internal secretory glands. *Nothing of the kind is to be found in current medical literature.*

The subject is of unusual interest to physicians in every branch of practice, and especially to general practitioners, for whom the series was prepared.

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fect in the production of the hormones of the internal secretory glands. Increasingly greater stress is being laid on the importance of these chemical messengers, and there is now little doubt that in health, as well as in disease, they regulate and correlate the metabolic activities of the body."

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F. R. S. M., Los Angeles, Cal.

tories conquered by Lister and Pasteur are destined to pale into honorable insignificance. The ductless glands or their hormones come to us as peaceful conquerors who brook no denial. They lighten our darkensses and show us miracles. In studying them one seems ever and anon to be on the trail of the Great Secret. . . ."

New York Med. Jour.

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Others have used pituitrin to induce labor in conjunction with bougies, bags, etc.

Pituitary Extract in the First Stage of Labor.

Most authorities advise against the use of the remedy when the cervix is not well dilated or dilatable. There is danger of asphyxia and of separation of the placenta as the result of the powerful contractions meeting the resistance of the firm cervix. Hence I have never used the drug in this type of case, and feel that it is particularly to be avoided in primiparae. In such cases if the patient becomes exhausted and labor does not progress it is much better to give some morphine and scopolamine and allow nature to rest and recuperate and the nervous system to quiet down. Dilatation will then gradually occur and later on when it is almost complete or when the second stage has actually arrived, the pituitrin may be used with good effect to aid in expulsion.

At the latter part of the first stage when the cervix is more than half dilated and the head well engaged we may use moderate doses of pituitrin with good effect if required for a tendency to inertia and failure to maintain progress.

Owing to a fear of causing cervical laceration I am personally rather chary about using pituitrin until complete dilatation has occurred, although recognizing the fact that it is perfectly proper to resort to it in the conditions mentioned above. If the cervix seems quite soft and dilatable and the pelvis evidently does not interpose any obstacle to progress and the arrest is merely due to ineffective pains or refusal of the patient to make expulsive efforts, then it is better to complete the dilatation with pituitrin rather than manually or instrumentally.

Pituitrin in the Second Stage of Labor.

Here is the ideal stage for its use. Many of our patients become tired,

nervous and hysterical at this time. We cannot induce them to aid nature and use their abdominal muscles as they should, or the pains lose their force and regularity and labor ceases to progress, or perhaps the presenting part is rather large and fits tightly in the pelvis (although engaged) and fails to come down and rotate as it should.

In this type of case pituitrin comes nobly to our aid. It renders the irregular, ineffective pains strong and efficient, and the patient seems to feel again the impulse to aid nature, especially if the edge of her suffering be dulled by the moderate use of ether or chloroform, which may be so regulated as to prevent overaction and laceration.

Thus in protracted second stage labor we have, I think, the indication par excellence for pituitrin. Its use at this time will frequently prevent our having to resort to forceps, and will most legitimately save our patients from many hours of needless suffering.

Pituitrin in the Third Stage of Labor.

It is stated by a good authority that we should never resort to manual removal of the retained placenta until we have tried the effect of pituitrin.

This is probably good advice, but the fact remains that for some reason pituitrin often fails to produce efficient contractions at this stage, and is a disappointment. I have used it several times to aid such cases, but have not had much success and have generally been obliged to remove the placenta manually.

However, this retention of the placenta seldom occurs in cases in which pituitrin has been given in the second stage.

I have been struck with the fact that the uterus under these circumstances responds much better to the stimulus of the hand in Crede's manoeuvre, expels the placenta very promptly and completely if you help it a little.

It is claimed, and, I believe, true, that a period of atony is apt to come at the

end of the third stage when pituitrin has been used earlier in labor. This is a reaction from the powerful contractions, and is possibly dangerous, as it favors post partum hemorrhage.

Hence the custom of giving a full dose of ergot at the termination of labor is not to be departed from merely because pituitrin has been used, but should be even more rigidly insisted upon.

Pituitrin in Incomplete Abortion or Miscarriage.

In these cases the remedy is uncertain. When first using the preparation I had two cases in succession in which it worked splendidly. In the first one I was called to see a patient about 2½ months pregnant who gave the history of pains and the expulsion of the foetus. On requesting to see what had passed I was shown the foetus in the transparent, ruptured amniotic sac. The patient wanted to know if "Everything had passed" and said that she had had no more pains for some hours, but continued to flow rather freely. I gave an ampoule of pituitrin and in an hour the remaining decidua was expelled complete.

The second case was practically the same, save that the amniotic sac had ruptured and only the foetus had come away. Here also pituitrin promptly caused the rest of the ovum to be expelled.

A third case was somewhat different. The woman was about 4 months pregnant, and had been ill and passing an offensive discharge for over a week. She had a chill and sent for me. I found a temperature of 103° and on examination the cervix was patulous and the ovum could be felt, like a "bag of bones" through it. There was evidently a good deal of sapremia.

Being afraid of spreading the infection by instrumental removal I gave pituitrin and on returning a few hours later was shown the macerated foetus

and sac completely expelled. Recovery was prompt.

But since these cases I have tried pituitrin in several others without any striking success and have had a number of times to resort to other means of emptying the uterus.

Pituitrin in Placenta Praevia.

My experience is limited to 3 cases of marginal placenta praevia. In two of them hemorrhage occurred before full term and in the third not till labor was due.

Case I: III para, was a normal presentation, but began to flow moderately when labor started at term. On examination the os was dilated to about the size of a dollar and the edge of the placenta could be felt. I ruptured the membranes and gave an ampoule of pituitrin. The pains became at once more forcible and regular and the child was rapidly expelled. It proved vigorous, and the placenta was quickly brought away by Crede's method. The cervix was not lacerated.

Case II: Multipara whom I had delivered by Braxton Hicks' version, in a case of placenta praevia marginalis the year before. She became pregnant again and at about the 7th month began to have hemorrhages, but did not notify me at the first one, which ceased spontaneously. In about a week hemorrhage came on again more profusely and was accompanied by irregular pains. The os was patulous. I ruptured the membranes and gave pituitrin. The hemorrhage checked and the dead foetus was promptly expelled. No laceration occurred.

Case III: II para colored, 8 months advanced. Had engaged another doctor to care for her, but could not get him when flowing began, so lost considerable blood, waiting for him before summoning me. I found her quite exsanguinated and having ineffective pains; cervix dilated to about a half dollar, placenta edge could be felt; bed

saturated with blood. Pituitrin was given and membranes ruptured.

Strong pains followed and expulsion was rapid. The placenta came away well, but oozing continued. Cervix did not show any laceration so I packed the uterus for fear that even a little excess of bleeding might prove fatal. Convalescence was satisfactory.

The baby was born alive but died in 36 hours.

I am convinced that pituitrin is of great value in placenta praevia.

Pituitrin in Eclampsia or Threatened Eclampsia.

On account of the fact that it raises blood pressure some have thought pituitrin dangerous in this condition, but other authorities sanction and advise its use provided labor is present but a tendency to inertia is noticeable.

I have used it in two cases.

Case I. Elderly primipara, became edematous in her 7th month and showed albuminuria and high blood pressure. Sent to hospital; eliminative measures and diet tried faithfully, but when about 8 months advanced a convulsion occurred. When I reached the hospital I found that she was semi-conscious and having pains. The cervix was somewhat dilated and soft. I waited for some time in hopes that the pains would help things along, although all preparations were made for a rapid delivery.

A second convulsion occurred. The uterus was about half dilated. It was necessary to deliver promptly. The question arose as to whether I should dilate manually or aid the pains with pituitrin. I decided to take a chance on pituitrin.

Under its influence the dilatation rather rapidly became complete, but the effect wore off, and, rather than repeat it, I had her etherized and easily delivered a living child with forceps. Both mother and child lived. The baby required careful management, but is now thriving at a year of age.

Case II: Also became albuminuric at about 7½ months; sent to hospital and the usual eliminative measures tried. But the urine did not clear up and the toxic symptoms continued; great edema; considerable headache; urine scanty and highly albuminous; blood pressure gradually rising till it reached 190 to 200.

After consultation, it was decided that to wait meant eclampsia without doubt. So anesthetic was given and a voorhees bag introduced. This caused pains but not much dilatation in spite of traction with a weight for about 36 hours. Patient demanded relief. Pituitrin was given to increase pains, which it did, and when bag was about expelled it was removed. Pains continued for a time, but gradually began to die out. Dilatation was, however, by this time quite well advanced. So an anaesthetic was given and I completed the dilatation manually and delivered the child by version. It was dead, but the mother made a good recovery.

In a second breech case the water broke at the onset and a long first stage ensued as the child was a ten pounder and the mother a primipara.

Morphine and scopolamine were used to gain time for dilatation. When dilatation was complete the progress almost ceased from inertia as nearly 48 hours had elapsed and the patient was exhausted. So we resorted to repeated small doses of pituitrin and were finally rewarded by the birth of a vigorous child without damage to the mother.

In two other breech cases I have waited till the presenting part was distending the perineum, and then given pituitrin to prevent delay in the birth of the after coming head. The effect seemed most excellent to me.

Pituitrin in Delay in Second Stage from Malpresentation.

In cases of R. O. P. with slow progress pituitrin has proved very useful. Also in a face presentation.

In one breech presentation the cord prolapsed when the water broke. Pituitrin was given to expedite delivery as the patient was a primipara. The result was good and a living child was promptly delivered, although I fractured an arm in extraction.

Dangers.

Pituitrin has in a number of reported cases caused rupture of the uterus.

This, however, probably would seldom occur if the drug were only used in cases in which the head has become well engaged or even entered the pelvic cavity. If a pronounced disproportion exists there is danger that the powerful contractions may cause rupture if they are unable to force the presenting part onward in the normal manner. A rigid undilated cervix may have a similar effect.

Lacerations of the cervix are to be feared if unduly powerful contractions occur when dilatation is not complete. They are especially apt to occur in diseased or friable crevices, or those scarred from previous traumatism.

Asphyxia of the child may result from prolonged contractions without proper intervals of relaxation. Hence moderate doses are to be recommended.

Premature detachment of the placenta has been reported. Also the formation of a contraction ring.

Perineal lacerations should not be more frequent if anaesthetic is used in the expulsive stage and the progress of the presenting part controlled.

Technique.

All authorities unite in advising the intra-muscular injection as being most satisfactory.

Avoid alcohol in sterilizing your syringe.

Moderate doses ($\frac{1}{2}$ ampoule) are often enough to start with and will not produce such tumultuous contractions as larger doses.

All preparations for delivery should be completed before pituitrin is given.

Ether or chloroform should be at hand to control overaction.

A full dose of ergot should always be given at the close of labor if pituitrin has been used, to guard against atony.

WIDOW GETS \$1000 FOR AUTOPSY HELD UPON HUSBAND.

Recently Superior Judge Grant Jackson ruled that a widow is entitled to the control and disposition of the dead body of her husband and that it cannot be touched without her full knowledge and consent.

On this theory he gave judgment for \$1000 in favor of Mrs. Jessie R. Greenslade against the E. E. Overholtzer Sons Company and Dr. Curtis Brigham, because an autopsy was performed on the body of A. L. Greenslade without the consent of the widow.

A. L. Greenslade died in Long Beach, May 18, 1915. The body was sent to the local funeral parlors, and plans made for its interment in Rosedale Cemetery. A brother and a sister made practically all the funeral arrangements, and at their request, according to the evidence, the autopsy was performed. They were not certain what was the cause of death, and as the attending physician had been baffled as to the nature of the malady which proved fatal, it was determined that a post-mortem should be held.

Dr. Brigham, at that time a professor in the Los Angeles School of Osteopathy, performed the autopsy before a class of medical students and nurses from the Pacific Hospital. It was discovered that death resulted from cancer of the liver, and that the liver was abnormally large.

The widow, Mrs. Greenslade, asserted that the shock, when she learned an autopsy had been held, had a lasting effect on her nervous system and caused her great mental anguish and distress. She asked \$20,000 damages.

SOUTHERN CALIFORNIA PRACTITIONER.

A MEDICAL, CLIMATOLOGICAL AND SOCIOLOGICAL MONTHLY MAGAZINE.

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EDITORIAL

AN IMPORTANT ANNOUNCEMENT.

It is a pleasure to be able to announce to readers of The Southern California Practitioner a series of articles by Dr. Henry R. Harrower, now of Los Angeles, on "The Diagnosis of the Internal Secretary Disorders." This will commence in the issue for May, and will take up this increasingly important subject from the standpoint of the general practitioner.

The part that the ductless glands play in health and disease is none too well appreciated as yet, and many a puzzling condition is made clear when the influence of the hormones is understood. There is practically no convenient literature upon the all-important diagnos-

tic phase of this subject. True, there are hundreds of papers in a dozen languages dealing with the pathology and physiology, prognosis and treatment of the better known endocrinous diseases; but it is no easy task to collate from these the essential, practical points which make for success in our work. This has been done in this series, and done extremely well; and we are confident that our readers will keenly appreciate this innovation.

There will be ten or more concise and practical articles. A "Question-Clinic" will be arranged for that will be open to all paid-up subscribers, and this will make the subject of the most possible practical value to all.

How about your subscription?

EDITORIAL NOTES

Dr. William L. Rodman, president of the American Medical Association and professor of surgery at the Medico-Chirurgical College, died March 8th after a short illness from pneumonia, aged 58 years.

Alameda is planning a hospital for tuberculosis in the Livermore hills.

Dr. Charles H. Mayo is a recent arrival at the Hotel Maryland, Pasadena.

Dr. Jewett G. Leonard, a pioneer physician of Reno, died February 27th, aged 72 years.

Dr. C. E. Standlee has been appointed district surgeon for the Southern Pacific railway at Downey.

Dr. E. N. Reed has removed his offices from the Butler building to 301-302 Juniper building, Santa Monica.

The increasing practice of Dr. Garcelon, of Victorville, has made room for an assistant, Dr. Sam Richards of El Paso, Texas.

There is a movement on foot to hold the 1918 meeting of the Pan-American Medical Congress in Buenos Ayres, Argentine Republic.

Dr. H. A. Brown, of Reno, was operated upon for mastoid trouble at the S. P. hospital, San Francisco, and is now convalescent.

Dr. T. C. Edwards has been appointed on the Board of Health of Salinas to fill the vacancy caused by the resignation of Dr. H. T. Crabtree.

Dr. G. Maurice Crow of 1725 Monterey Road, South Pasadena, has been in the hospital for a number of weeks, following a nervous breakdown.

Dr. C. A. Briggs has resumed practice in his offices in the Kinney-Kendall

building, Pasadena, after an enforced vacation of three months due to illness.

The Physicians and Surgeons Telephone Exchange, 607 W. P. Story Building, has published an assessment of one dollar per share against its capital stock holders.

John Dudak, the circus employe who was bitten by an infuriated hyena at Venice February 19th, was given anti-tetanus serum and has apparently recovered.

Dr. Frederick M. Rossiter is the new resident physician of the Long Beach Sanitarium and is associated with Dr. R. A. Terry, 301 First National Bank building.

Moving picture and stereopticon lectures are being planned for the general public at the meeting of the California State Medical Society in Fresno, April 18, 19 and 20th.

Dr. R. H. Chittenden and his wife, Dr. M. L. Chittenden, of Berkeley, are recent additions to the profession of Los Angeles. Their present address is 339 West Twenty-second street.

Santa Monica is to have a woman physician to assist Dr. Jenks in the examination of school children. Superintendent Rebok and Dr. E. N. Reed are a committee to choose the new officer.

Judge George A. Gibbs has been elected president of the Pasadena Hospital Association, following the retirement of Dr. Henry Sherry, who was president of the board for four years.

A romance that began on a wintry day in Cook county hospital, Chicago, culminated in sunshiny California when Dr. Louis M. Kane and Miss Frances Stuart were married beneath the palm trees at San Gabriel Mission.

Dr. M. S. Kelliher, county physician at Ynez, has resigned. Apparently the

Doctor was expected to use his little stipend for what should justly be regarded as county expenses, in the transportation of patients to the county hospital.

At a meeting of the board of directors of the Children's Hospital Society, held on March 9th, Dr. G. B. Speir, 512 Story Building, was appointed oral surgeon on the staff of the Children's Hospital.

Dr. Elmer R. Pascoe has been appointed assistant health commissioner in the Los Angeles city department, succeeding Dr. L. H. Freedman, who resigned to enter private practice. Dr. H. Wallace Dodge will take Dr. Pascoe's place as district physician.

The Board of Control is well satisfied by its six months' trial of scientific diet for state wards, which affects some 16,000 inmates of state institutions, comprising prisons, insane hospitals, etc. Dr. M. E. Jaffa, professor of chemistry in the University of California, was selected as nutrition expert.

Papers were read by Dr. Eugene Stadelman and Dr. F. L. Rogers at the meeting of the Long Beach branch of the Los Angeles County Medical Society, February 27th, at the Schuyler. A resolution was adopted emphasizing the need of a permanent drainage system for the district near Signal Hill.

Dr. Joseph C. Bloodgood of Baltimore, associate professor of surgery in the medical department of Johns Hopkins University, is coming to San Francisco this month as a guest of the California Academy of Medicine and will deliver an address on cancer. This is a part of the campaign of the American Society for the Control of Cancer.

Dr. Wilbur F. Burke, former director of the Burke Sanitarium in Sonoma county, sentenced to serve ten years in San Quentin for the use of dynamite with intent to commit bodily harm against a woman living at the sanita-

rium, was pardoned by Governor Johnson January 26th. He is 65 years of age.

There is evidently good surgery being done in El Paso. On the second instant a blood clot was removed from the brain of an infant of thirty hours, by Dr. J. E. Keltner, assisted by Dr. J. G. McAlpine, Dr. J. A. Rawlings and Dr. E. B. Galloway. A hemorrhage had caused paralysis of the right side, which has already partially disappeared following the operation.

It is reported that six hundred pupils of the East Vernon school, Los Angeles, were expelled because their parents refused to permit them to be vaccinated in an attempt to stop an epidemic of smallpox that had already reached some twenty odd cases. Wouldn't it be just as well to let the progeny of such foolish parents be decimated by the disease? The children of sensible parentage would be protected by vaccination, thus favoring nature's plan of the survival of the fittest.

In a recent case, it is reported that Drs. French and Rinkenberg testified that Mrs. Emma Parlee's back was broken, and produced X-ray photographs which seemed to show the fracture. The case was a suit for \$40,000 damages against the Pacific Electric railway, and it was important to determine whether or not the individual was permanently injured. Dr. Brainerd declared that Mrs. Parlee was suffering from hysteria and that her injuries were not severe. Dr. Soiland, appointed by Judge Myers, took an X-ray photograph in which there appeared to be no fracture. The appointment of a radiographer by the court in such cases would be quite ideal if it were not that such appointments are liable to be made on the basis of reputation rather than of ability, and positive findings in radiography are especially likely to gain credence.

BOOK REVIEWS

REFERENCE HANDBOOK OF THE MEDICAL SCIENCES. Embracing the entire range of Scientific and Practical Medicine and Allied Sciences. By various writers. Third edition. Completely Revised and Rewritten. Edited by Thomas Lathrop Stedman, A.K., M.D. Complete in eight imperial quarto volumes. Volume VI, 967 plus 6 double-column pages, illustrated by 489 engravings and 7 full-page plates in black and colors. Wm. Wood & Co., New York. Price per volume, \$7.00 in cloth, \$8.00 in leather, \$9.00 in half morocco.

The sixth volume of this great undertaking appears with commendable promptness. It contains 967 double-column pages; five hundred and six separate articles, by one hundred and eleven writers, all authorities upon their several topics. It is illustrated by four hundred and eighty-nine cuts in the text, and seven full-page plates in black and colors. The subjects run from "Ligation of Arteries" to "Ozæna." The "Reference Handbook" represents the investment of a sum of money that would be considered a fair capitalization for many publishing houses. This is not a speculation as the immediate success of former editions has demonstrated, but a sound business investment as, in a smaller way, every subscriber will testify to.

Space prohibits an enumeration of the many excellent articles in this volume, which are of such variety and importance that no physician or surgeon can look listlessly from cover to cover without finding something that will tempt him to pause for a more careful perusal. There are comprehensive articles on the ligation of arteries, the liver, the lungs, the lymphatic system, malaria, the medical licensing boards, the history of medicine, mental diseases, the nasal cavities, the naval medical service, the neck, nematoda, occupational diseases, old age, and many and varied other subjects. This continues to be the standard reference handbook of the medical sciences.

We could criticise this work, just as

a cat may criticise a king, but we are not specially given to the exercise of feline propensities. Furthermore, there is no work more worthy of your confidence.

AUTOPLASTIC BONE SURGERY. By Charles Davison, M.D., Professor of Surgery and Clinical Surgery, University of Illinois, College of Medicine; Fellow of the American College of Surgeons; Surgeon to Cook County and University Hospital, Chicago; and Franklin D. Smith, M.D., Clinical Pathologist to University Hospital, Chicago. Octavo, 369 pages, with 174 illustrations. Cloth, \$3.50, net.

The authors have succeeded in presenting, in clear and concise form, a vast array of facts and theories covering this important subject. The work brings to the reader not only the proved results of the authors' own practice and experimentation, but it also includes a painstaking resumé of the literature which has appeared during the last few years.

Wherever the literature is at variance with their experimental and clinical deductions, the authors have presented the literature as it exists in addition to their own findings, thereby permitting the reader to draw his own unbiased conclusions. The authors' own opinions are based upon histopathological study and analysis of tissues removed from experimental animals at varying periods of time after an operation had been performed. This experimentation includes not only problems with the regeneration of osseous tissue, but problems in technic, mechanics and minor problems in this difficult field of surgical science.

Perhaps the most important section of the work is that which treats of the repair of intractable, recent, simple fractures by the autoplasmic transplantation of bone. It is to be hoped that the methods therein described will largely replace the use of metallic foreign bodies for fixation in fractures of

this character which require open operation.

The book is amply and admirably illustrated with original photographs and röntgenograms showing the methods employed and the results attained by the authors in their extensive experience.

Successful transplantation of bone in human beings has been accomplished in the East for centuries. It was later introduced into Italy and thence into Europe. In the early history of the transplantation of bone, heteroplastic grafting of bone from animals was more extensively employed and with many reported successful cases. The earliest report dates back to the year 1682. During this year is found the following decree against Jobi Meekren: "Chirurgicum ossis cranii fragmentum anferre jussit, sique, curatione alia adhibita excommunicationis vim effugit. Jobi a Meekren observat medicochirurg." Jobi Meekren transplanted a piece of the skull of a dog into the defect in the skull of a soldier. This was probably the earliest successful case of heteroplastic transplantation. In those early days of superstition when the Church ruled all it surveyed, Jobi Meekren was forced to remove the implanted bone under the ban of excommunication from the Church which refused to recognize such a monumental work and referred to it as "an un-Christian" method of treatment.

This is one of the most readable and lucid monographs that we have had the pleasure of reviewing.

Despite the brief lapse of time since the publication of the fourth edition of this book, numerous additions and a few modifications were necessary in this new edition. New and better instruments have made the deep urethra more accessible to rational local treatment, but likewise have offered suggestions for varied mutilations. In their time the ovaries were the object of the

"furor operandi." and it appears now as if the colliculus seminalis and the seminal vesicles must be substituted for them, and must be sacrificed to demonstrate brilliant technic. Proceeding from one extreme to another, one encounters the beseeching demands of psychotherapy. That psychotherapy is new is not true, and that it is very often the true treatment is not new. Even psychotherapy for sexual neurasthenic troubles is nothing new. The author advocated it in the first edition of this book (published in 1888), when urology was in its toddling clothes, and at a time when the subject of sexual neurasthenia was strictly tabooed in polite medical society. Even a superficial study of the history of medicine will convince anyone that psychotherapy was used at all times by the physicians of all nations. Fakers also, at all times, have tried to take hold of psychotherapy, and some of them have been exceedingly successful with many patients; but in order to treat rationally any case of disease, first of all a correct diagnosis must be made. "It is either gross ignorance or a brazen and criminal impertinence that anyone should have the temerity to subject a fellow human being to any kind of healing, mental or other, without having previously mastered the knowledge necessary to discriminate between the nature of a sickness in which mental healing can accomplish anything and other forms of diseases where different means must be used to protect the patient against suffering or even against premature death."

THE MEDICAL CLINICS OF CHICAGO.
January, 1916. Volume I, Number 4.
Published Bi-Monthly by W. B. Saunders Company, Philadelphia and London.

Beginning with the March, 1916, issue, the Medical Clinics of Chicago will include the Clinics of Dr. James T. Case, (Battle Creek), held in St. Luke's Hospital, Chicago.

A PRACTICAL TREATISE ON INFANT FEEDING AND ALLIED TOPICS. For Physicians and Students. By Harry Lowenburg, A.M., M.D., Assistant Professor of Pediatrics, Medico-Chirurgical College of Philadelphia; Pediatricist to The Mount Sinai Hospital; Pediatricist to the Jewish Hospital; Pediatricist to the Jewish Maternity Hospital; Consulting Pediatricist to the Hebrew Orphans' Home; Assistant Pediatricist to the Medico-Chirurgical Hospital and The Philadelphia General Hospital; Formerly Instructor of Pediatrics, Jefferson Medical College. Illustrated with 64 Text Engravings and 30 Original Full-page Plates, 11 of Which Are in Colors. Philadelphia: F. A. Davis Company, Publishers. English Depot, Stanley Phillips, London. 1916. Price, \$3.00 net.

Probably the most striking feature of this treatise is the illustration of stools, to which purpose ten perfectly good full page lithographic plates are devoted. In general, the author follows the German school. The top-milk and milk and cream mixtures are abandoned in favor of diluted whole or skimmed milk, which are advocated as simple and efficient. There is added an excellent chapter by Dr. John B. Deaver on the Surgical Treatment of Infantile Pyloric Obstruction.

CANCER OF THE STOMACH. A Clinical Study of 921 Operatively and Pathologically Demonstrated Cases, by Frank Smithies, M.D., Gastro-enterologist to Augustana Hospital, Chicago. With a Chapter on the Surgical Treatment of Gastric Cancer, by Albert J. Ochsner, M.D., Professor of Clinical Surgery of the University of Illinois. Octavo of 522 pages with 106 illustrations. Philadelphia and London: W. B. Saunders Company, 1916. Cloth, \$5.50 net; Half Morocco, \$7.00 net.

This work attempts to set forth the facts which are considered valuable from a study of 921 operatively and pathologically demonstrated instances of gastric cancer. The cases and their records comprised part of the writer's services, extending over ten years, at the University Hospital (Ann Arbor, Mich.,) the Mayo Clinic (Rochester, Minn.,) and his present clinic at Augustana Hospital. It is at least a decade since a monograph upon this subject appeared. The interim has been prolific in its contributions to our better clinical, pathologic and surgical knowledge

of gastric cancer. The practical worth of the more important of these advances is emphasized in this monograph.

With the object of demonstrating the relative worth of Roentgenographic evidence in gastric cancer, there is presented a series of Roentgenograms in association with other clinical and surgical findings. In the majority of cases, clinical diagnosis was quite possible without the added X-ray examination; and in clinically doubtful cases, the Roentgenographic diagnosis was similarly dubious. The plates form, however, an interesting accessory record to the histories, and aid in the selection of cases likely to be benefited by surgical procedures, by indicating, roughly, the location of the growths and the extent that they invade the gastric wall or involve other viscera.

We should welcome enthusiastically any light that may be shed upon the stygian darkness of cancer of the stomach. Ochsner is a leader among those who have demonstrated the value of early operation in gastric cancer. Unfortunately, it is still the rule that the diagnosis of cancer of the stomach is made too late for surgical relief to prove permanent. It is to be hoped that the present wave of education and publicity regarding cancer will stimulate earlier diagnosis.

THE STARVATION TREATMENT OF DIABETES. With a Series of Graduated Diets Used at the Massachusetts General Hospital. By Lewis Webb Hill, M.D., Children's Hospital, Boston, and Rena S. Eckman, Dietitian Massachusetts General Hospital, Boston. With an Introduction by Richard C. Cabot, M.D. Second Edition. Boston, Mass. W. M. Leonard, 1916.

One difficulty in the general adoption of the so-called Allen starvation treatment of diabetes is the detailed knowledge of food composition and caloric value which it requires. And that difficulty is met by this little volume. The diets were worked out by Miss Eckman, head of the diet kitchen at the Massachusetts General Hospital. The demand

for such a work is evidenced by the appearance of this second edition some five months after the first.

THE PRACTICAL MEDICINE SERIES. Comprising Ten Volumes On the Year's Progress in Medicine and Surgery. Under the General Editorial Charge of Charles L. Mix, A.M., M.D., Professor of Physical Diagnosis in the Northwestern University Medical School. Volume IX. **SKIN AND VENEREAL DISEASES.** Edited by Oliver S. Ormsby, M.D., Professor and Head of the Department of Skin and Venereal Diseases, Rush Medical College, with the Collaboration of James Herbert Mitchell, M.D., Research Fellow in Pathology, Rush Medical College. **MISCELLANEOUS TOPICS,** Edited by Harold N. Moyer, M.D. Volume X. **NERVOUS AND MENTAL DISEASES.** Edited by Hugh T. Patrick, M.D., Professor of Neurology in the Chicago Policlinic, Clinical Professor of Nervous Diseases in the Northwestern University Medical School; Ex-President Chicago Neurological Society. Peter Bassoe, M.D., Assistant Professor of Nervous and Mental Diseases, Rush Medical College. Series 1915. Chicago. The Year Book Publishers, 327 S. LaSalle Street. Price of Each of These Volumes \$1.35. Price of the Series of Ten Volumes, \$10.00.

The pernicious influence of Mars is indicated by the prominence given War Dermatoses, Neuroses of the War, and Insanity and the War. These little volumes that fit the pocket, bear evidence of master ability in the art of extracting and concentrating the recent literature on the subjects they embrace.

CANDY MEDICATION. By Bernard Fantus, M.D., Professor of Pharmacology and Therapeutics, College of Medicine, University of Illinois, Chicago. St. Louis: C. V. Mosby Company. 1915. Price \$1.00.

Though possibly there is still nothing new under the sun, it is quite certain that no volume on this subject has appeared heretofore in any language. Nauseous messes may appeal to some patients, but usually the pleasant preparations are appreciated by adults as well as by children. Candy medication is applicable to a large and ever increasing number of drugs. It increases tolerance and decreases aversion, and by its very attractiveness impels greater constancy and regularity in the matter of dosage. Fantus has done a

true service to humanity through presenting potent remedies in palatable form for both adults and children. The list of remedies treated is too long to give in this review. Besides, you will buy the book sooner or later.

DIAGNOSTIC METHODS. A Guide for History Taking, Making of Routine Physical Examinations and the Usual Laboratory Tests Necessary for Students in Clinical Pathology. Hospital Internes, and Practicing Physicians. By Herbert Thomas Brooks, A.B., M.D., Professor of Pathology, University of Tennessee, College of Medicine, Memphis, Tennessee. Third Edition. Revised and Rewritten. St. Louis: C. V. Mosby Company. 1916. Price \$1.00.

It is a pleasure to note the appearance of the third edition of this handy little resumé of diagnostic methods.

A HANDBOOK OF INFANT FEEDING. By Lawrence T. Royster, M.D., Attending Physician Bonney Home for Girls and Foundling Ward of the Norfolk Society for the Prevention of Cruelty to Children, Physician-in-Charge of King's Daughters' Visiting Nurse Clinic for Sick Babies. Illustrated. St. Louis: C. V. Mosby Company. 1916. Price \$1.25.

This little work is written for the general practitioner, to whom it is dedicated. It gives in brief space the practical part of modern infant feeding, that is spread through many pages in the more comprehensive works on the subject.

VENEREAL DISEASES. A Manual for Students and Practitioners. By James R. Hayden, M.D., F.A.C.S., Professor of Urology at the College of Physicians and Surgeons, Columbia University, New York; Visiting Genito-Urinary Surgeon to Bellevue Hospital; Consulting Genito-Urinary Surgeon to St. Joseph's Hospital, Yonkers, New York. 12 mo., 365 pages, with 133 illustrations. Cloth, \$2.50 net. Lea & Febiger, Publishers, Philadelphia and New York, 1916.

Hayden's work on venereal diseases has passed through three revisions. The new fourth edition has been carefully revised and considerably enlarged. The addition of numerous illustrations, for the most part showing the author's own cases and methods of treatment, has greatly enhanced the value and interest of the work.

SOUTHERN CALIFORNIA PRACTITIONER

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THE MANAGEMENT OF THE BREAST-FED INFANT.*

BY DR. J. F. FRIESEN, LOS ANGELES.

The object of this paper is to call attention to some of the principles that govern the proper nursing and nutrition of the infant during its early career in life.

Nutritional disturbances in the baby are of very frequent occurrence and they sometimes tax the ingenuity of the attending obstetrician more than does the care of the mother.

When one considers that one-fourth of all deaths occur during the first of life, and that of these about 60% are due to gastro-intestinal disturbances, he begins to realize how very important the proper nutrition of the infant becomes.

In the first place, it is absolutely necessary that the physician in charge have the complete confidence and co-operation of the patient and attendant. It only happens too often that the infant becomes a victim of a practical nurse who knows more than the attending physician, or a mother, grandmother or neighbor who has raised lots of babies.

Most nourishment disturbances in the infant are caused through ignorance

of the young mother and it is the duty of the obstetrician to investigate the maternal conditions and give the necessary advice.

Mothers who have an uncontrollable temper, who are unhappy, unwilling to nurse their infants, hurried in the details of their life, irregular in their periods of rest and in their diet and exercise, are unfit to act as the source of food supply for their infants.

In a person who is laboring under a nervous tension the vaso-constrictors are working overtime due to this constant stimulation of the sympathetic nervous system, which will cause an inhibition of all the secretory organs. This causes marked changes in both the quantity and quality of the mammary product in proportion to the nervous excitability of the mother.

The importance of the nervous element in milk secretion pertains more to the women who are subject to the customs and vicissitudes of modern life, than those who live in a natural way. According to statistics made by Fischer of the conditions as they exist in New York City today, 90% of the poor

*Read before the Los Angeles Obstetrical Society, March 14, 1916

mothers are able to nurse their children while only 17% of the rich mothers are able to perform the same duty.

It is a matter of educating the mother and correcting these contra-indications to nursing, if possible. She must be taught that a happy temperament and an harmonious environment are desirable, that her diet, her exercise and her sleep must be regular, and thus will a great many colics in babies be prevented.

The one most important factor in depleting the milk supply is the nervousness of the mother. The breasts are flabby. The child will not go to sleep after nursing 15 to 20 minutes, but will fret and whine and lay on the breast for a half hour without being satisfied. Then it is advisable to feed the infant alternately with breast milk and bottle milk, at the same time improve the mother's general condition as her food will only turn to milk as her general health is improved. A day's outing to the country or seashore, with moderate exercise, a nutritious diet, and some of the galactogogues, will most always give us favorable results.

During the first few weeks of nursing, until the milk-equilibrium is established, over-feeding is much more commonly the source of trouble for the little youngsters.

An over-anxious nurse or grandmother often would stuff the newborn with cow's milk or condensed milk until the mother's milk comes in, and it also used to be the opinion of the profession to feed early and prevent the initial loss of weight.

Benestad in some newer studies has shown that it is impossible to prevent the initial loss of weight by supplying newly-born infants with milk from wet nurses, which seems to indicate a functional inability to utilize the milk during the first few days of life.

The most suitable food for the young infant is colostrum. Its fat and its sera-albumin are closely related to those

to which the infant has been accustomed in its intra-uterine life; with improvement in the digestive processes an increasing supply of mother's milk becomes necessary.

In the meantime, says Benestad, artificial feeding increases and prolongs the initial loss of weight.

It is my practice not to have the baby nurse at all the first eight hours, the second day once or twice, while water is given *ad libitum*, in the bottle every few hours; on the third and fourth day the number of feedings are gradually increased to every three hours.

Success in infant feeding depends not only on the composition of food, but also on the way in which it is given. The intervals of nursing should be definitely stated to the mother and adhered to. Some infants fed as often as every two hours, and even one hour, thrive and escape nutritional disturbances; most, however, at some period show dyspepsia of greater or less degree.

The infant stomach is not emptied under two hours. By adding fresh food to a fermenting residue will almost certainly give rise to a flatulent dyspepsia. The distress being worse in the evening, because of the day's accumulation. The advocates of the four-hour interval assert that first there is a greater supply of milk secreted in the breasts, and second, it gives the infant stomach a much needed rest and a better appetite.

It has been my custom to awaken the child every three hours during the day to be nursed, beginning at 6 in the morning and ending at 9 or 10, on retiring, and once at night, making seven feedings in twenty-four hours.

If the child thrives and gains weight then the night feeding is discontinued at four to five months and the interval of three hours increased to three and one-half hours, making it only five feedings in twenty-four hours.

Smith and LeWald have made some studies that have an important bearing on the digestion in infancy.

They believe the position of the baby during feeding is very important and advise that immediately before and after feeding, the baby should be held upright in order that swallowed air may be expelled. With the baby in a recumbent position, fluid gravitates to the posterior position of the stomach, covering the cardiac orifice; the air therefore cannot escape through the esophagus, and leads by pressure to vomiting and colic. A series of radiogram have shown that the infant swallows more or less air with the food. If this is a large amount, vomiting will nearly always take place.

A stomach thus distended necessarily interferes with digestion, and if the air is gradually forced through the pylorus it causes intestinal colic.

All this may be prevented by holding the child in an upright position before and immediately after feeding to favor the eructation of air. The instinctive posture which many mothers assume (if not taught otherwise by nurse or doctor) when they hold the baby up against the shoulder after nursing is the one in which the baby can most easily get rid of the undesirable swallowed air. Patting on the back or slight pressure on the epigastrium aids the process of eructation.

From the rocking cradle of our mothers, the modern training school for nurses have gone into the other extreme and under no circumstances is a squirming baby picked up from its bed. Then the mother comes along, picks up the baby and holds him against her shoulder in a desperate attempt to soothe away the colic with a little cuddling and patting, when the gas comes up and the baby goes to sleep.

Another frequent cause of a colicky and crying baby or one not thriving well, is where the composition of the mother's milk is at fault.

Human milk is the only ideal food for the infant, and means so much to its future welfare that before breast-feeding is interfered with and weaning even thought of, a milk analysis should be made, and if possible a healthy milk supply produced.

Protein is the most important constituent of the milk, but gives us the least trouble. Not so many years ago it was regarded as the element in milk causing the greatest disturbance. But since milk analysis has become more simple in its technique and more universal, we have found that the protein content remains more stationary. However, in woman leading a sedentary life and eating much meat, eggs and highly-seasoned food, it sometimes becomes the disturbing element in a faulty milk.

When we have a disturbance in fat metabolism there results the characteristic soap stools and in the urine it leads to an excess of ammonia in the urine, this condition now called acidosis.

The fat content is usually the most variable and troublesome. An excess of fat gives rise to vomiting, colic and diarrhoea. This usually occurs with a profuse secretion of milk, the child receiving far more than it could digest in both quality and quantity. It is best to put these cases on cereal water for twenty-four hours, then lengthen the feeding interval, and reduce the time of nursing say to five minutes and order an ounce of sterilized water immediately after each nursing, and thus diluting the milk. In these cases the mother is either having an excess of fat-producing foods such as starches, sugars and animal fats, or a deficiency of oxygen. Her diet must be corrected and outdoor exercise and deep breathing instituted.

Likewise a low fat content will cause indigestion and intestinal colic. All these variations are easily determined by simple tests. The simplest method

(Continued on page 80)

THE SOUTHERN CAJON

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ories conquered by Lister and Pasteur are destined to pale into honorable insignificance. The ductless glands or their hormones come to us as peaceful conquerors who brook no denial. They lighten our darkensses and show us miracles. In studying them one seems ever and anon to be on the trail of the great Secret. . . ."

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to determine the fat is by the cream gauge which is sufficiently accurate for clinical purposes.

Some of the causes just mentioned can easily be remedied. On the other hand a very nervous mother who is anxious and fretful all day, doesn't sleep at night and nothing but the constant worry of a sick, crying baby which she nursed as best she could, will hardly be adapted for breast-feeding, and the sooner the infant is removed from such a breast, the better for the infant.

We have all met the young, over-civilized mother, who does not want to

be inconvenienced by nursing her young. To her the virtues of human milk should be extolled.

The breast-fed infant will always be the stronger and withstand the infections of later life better, than the one brought up by artificial means.

Our plea should therefore be primarily for the education of the mother of those principles that govern her conduct during the nursing period, and especially so for the mother, who believes the modern fad of artificial feeding is equally as good as the natural method.

MAL-NUTRITION IN INFANCY.*

BY I. S. PLATT, M.D., LOS ANGELES.

There is nothing new or original in this paper, but a resume of the subject, as it now is. The reason I selected this subject is, because we meet this condition so often, and perhaps sometimes we do not give it the attention we should. It is so easy when a mother does not have sufficient milk, or for some other reason, does not nurse the baby, to tell her to get some patent food, as Malted milk, etc., and feed her child on it. When we do this to a healthy baby we are not doing justice to our patients.

This interesting subject is so large that it is impossible to cover it in the time given for this paper, therefore I will try to bring out the most important points and eliminate the minor details, and discuss it in a general way. When this subject is given careful consideration and one looks up the death rate, in the large cities, of children of one year or less, and when one knows the majority die from improper diet and care, one is impressed with the fact that much may be done to prevent this. I think that there is not a branch of preventive medicine that is more im-

portant. We may divide mal-nutrition into two general classes; first, born weaklings; second, those babies that receive improper care and diet.

First. Born weaklings. We may include premature babies, who, on account of lack of development, have not the digestive juices to take care of their food. Inherent diseases, as syphilis; children of parents, who, on account of poverty, are poorly nourished, and when one pregnancy follows another in rapid succession; children of parents suffering from chronic disease, as malaria, diabetes and kidney, etc.

Second. Children that receive improper care.

These children are healthy children at birth, but lack of care soon shows the result. I mean by lack of care, allowing the baby to nurse whenever handy, poorly ventilated homes, not taking babies out in the fresh air, cathartics, soothing syrups, pacifiers, neglecting the daily bath, bottle babies unless they receive especial attention and patience, patent foods, milk not properly modified, breast-fed babies

*Read before the Los Angeles Obstetrical Society, March 14, 1916.

who do not get enough milk and are really starving.

Symptoms. The weight is below the average and stays stationary and gains very slowly. The child's physical development is below normal. Dentition is delayed. The muscles are poorly developed, soft and flabby. The body is small, making the head seem large. The circulation is poor; they often have cold hands and feet, rapid heart. Digestive disturbances are common; in fact, the slightest change in diet is frequently followed by vomiting and diarrhoea. Frequently they have alternate constipation and diarrhoea.

The blood picture is one of a secondary anaemia, the severity of the anaemia depending upon the stage when the patient is seen. These children are all nervous and irritable, do not sleep well and cry a lot. Many times the lymphatic glands are enlarged. The child frequently has enlarged tonsils and adenoids.

Diagnosis. A careful history should be taken. Whether the baby has ever nursed; if so, how long, or the kind of food it has been taking. The weight at birth; when the child first began to lose weight, or fail to gain. A very careful examination should be made to be sure the child is not suffering from some other disease, as syphilis or T. B., and that the mal-nutrition is secondary. Blood and stools should be examined.

All other diseases should be ruled out before one starts treatment.

Prophalaxis and Treatment. Mothers should be educated to nurse their children regularly; in fact, the whole life of the child should be one of routine. Plenty of fresh air, night and day. The baby should be weighed every week, at first; later, once a month; and if the weight remains stationary her physician should be notified. If mothers were thus educated we would not see these serious and difficult cases. If we have not already, I think we will soon see, the influence of the better baby movement, which seems to be so popular now. Too much stress can not be laid upon getting our cases early. Treatment consists in, if the baby is on the breast, to add feeding of modified cow's milk. Our formula should be one to correspond to the weight, rather than the age. Be sure the milk is well diluted. It is easy enough to increase the milk content, rather than start with too strong a mixture and have a case of Enteritis. In getting the formula that will agree with the baby, many times it taxes our patience to the limit and is largely a question of try, try again, and common sense on the part of the physician and mother.

Prognosis. The prognosis, of course, depends on the case; also if the mother will follow our directions.

407 Delta Building.

HEMORRHAGIC DISEASE IN THE NEWBORN.*

BY DR. T. G. FINLEY, LOS ANGELES.

After one has practiced medicine a number of years he is impressed that he has seen a number of cases similar in character aside from those epidemic or endemic. They may have been very perplexing to him. Yet his more experienced fellow practitioner may refer to them as simple and common.

In medicine, however, all cases are of interest, no two being exactly alike, the symptoms, even the pathology, varying with the individual case, and it is by a careful study of this individuality which renders one practitioner more successful than another. The report of this case, which was one of hemorrhagic disease in the new-born, with congenital

*Read before the Los Angeles Obstetrical Society, March 14, 1916.

obliteration of the bile ducts, as a causative factor, is the third case of hematuria with a tendency to general hemorrhage occurring in my practice among children. I will briefly present the history with the clinical and pathological findings of one case in particular. The family history was carefully considered and syphilis eliminated; neither was there anything in the condition of the child to suggest it. Hemophilia was excluded. The mother, who was 27, was negative as to tuberculosis, and passed through her pregnancy without nephritic complications. The family history of the father was negative as to tuberculosis; he was 30 years of age, but anemic and weak chested, without active lung trouble.

Labor started at 9 p.m., the pains increasing in frequency and severity during the night, but toward morning the expulsive force lessened despite our efforts and about 5:30 p.m. I made a forceps delivery with little difficulty and no injury to the head aside from a slight bulging of the right eye, which appeared quite normal within forty-eight hours. The child was a female weighing nine pounds, and impressed us, not as a new-born babe, but as a little girl, a fact noted even by the father. Hair, finger nails and features all bespoke a more mature child having two well-developed lower incisors.

Mother and child did well for the first two days, when my attention was called to the fact that the child had passed but a small amount of urine.

Attempts were made to stimulate the kidneys with little success, neither were the bowels moved although oil, suppositories and enemas were carefully given during the first five days; the enemas returned stained but slightly, with meconium, apparently. On the evening of the fifth day the nurse telephoned that the diaper was stained with blood which seemed to come from the vagina, and that twitching and even slight convulsions had occurred; these

increased in severity, as did the hemorrhages until later she telephoned that the infant was "flooding;" indeed, it became so profuse that I deemed it advisable to pack the vagina and administer normal horse-serum. On the sixth day there was bleeding from the lips as well, the twitchings and convulsions increased in severity, and the child died on the afternoon of the seventh day of what I considered to be uremic convulsions. The conditions related appeared to warrant my insisting upon an autopsy, which the parents granted, and in company with Dr. O. I. Tower, I did upon the following day.

Autopsy on the body child B— L—, from memoranda furnished by Dr. Tower. Female of a few days.

Lungs: Dark blue in color, passively congested; somewhat firm to touch; crepitation lessened. Upon incision a dark red, frothy hemorrhagic fluid escaped; this condition existed in both lungs.

Heart: Enlarged about one-third without structural defects.

Liver: Enlarged; rich in blood; dark red in color; moderately firm.

Gall-bladder filled with dark colored bile, which we were unable to empty by pressure; further examination showed that the common duct was not patulous. No bile found in the duodenum.

Spleen: Slightly enlarged and congested.

Kidneys: About two and a half normal size, glistening red in color; upon section blood escaped. Upon scraping sections, cortical and medullary portions appeared about the same.

Uterus: Much larger in size than normal; filled with clotted blood, the mucosa red and congested, presenting bleeding surfaces.

Tubes and Ovaries appeared normal.

The appearance of the child was that of over development. There was no chilling of the child or congestion due to cold observed. There was no infec-

tion of the severed umbilical cord. When the hemorrhages commenced I could not account for them other than a possible tubercular diathesis; the hemorrhages being closely followed by symptoms of nephritis.

While the hemorrhages may have had their origin from the delayed labor causing atony of the vessels due to the condition of asphyxia produced; or to the trauma of forceps delivery; I feel from the delayed symptoms and post-mortem findings justified in ascribing the child's death to congenital absence or occlusion of the Common Bile Duct.

UBIQUITY OF THE DIPHTHERIA BACILLUS.

It has long been known that diphtheria germs are present in the throats of many perfectly healthy persons and that many cases of this disease may be accounted for only by their infection from such "carriers." To what extent these germs occur among healthy persons has been a point that has never been definitely determined, some workers claiming that as many as one in every twenty persons carried these germs and distributed them more or less indiscriminately. To determine this point the U. S. Public Health Service conducted an investigation of the prevalence of diphtheria carriers in the city of Detroit during the winter of 1913-14. This investigation stands as one of the most thorough and painstaking researches of its kind.

Should this report be read by all of the inhabitants of Detroit over 4000 of them would recall the visit of the "Health Officer" who examined their noses and throats and took "cultures" from both locations.

In the laboratory the officers of the service examined the 8758 cultures taken from 4093 persons; five bacteriologists examined the "smears" from an average of 158 cultures a day. The results of this examination were that very nearly one per cent—.928% to be

exact—of all the persons examined was found to carry diphtheria germs in their throat or nose or both.

One per cent does not ordinarily sound large to the average person, but let us see what it means to the individual. In time of epidemic prevalence probably one in every hundred persons he meets has diphtheria germs in his throat and in all probability on his hands and clothes as well, since it is one of the most common practices in the world to put the hand to the mouth. It is probable that the average individual comes in contact with a hundred or more persons every day and is hence practically daily exposed to infection with diphtheria. Some persons, mainly those remaining at home, associate with but few, but other members of the household are not so isolated. School children come in close contact often with more than a hundred others in a day. Occasionally one may even see a hundred persons on a single street car and none will doubt that many more than that number will cough into the air of a moving picture theatre during an evening.

To demonstrate further what one per cent means, let us see what are the actual figures. In 1914 the official census of Detroit was 537,650. One per cent of this is 5376. It would be difficult indeed for any one living in Detroit to avoid contact with one, two, five or more of these 5376 disseminators of diphtheria germs. Nor is there reason to believe that in time of epidemic the figures for any other large community are lower in proportion.

These data gathered by the Public Health Service, as well as data of the same nature obtained by other workers, demonstrate one of many reasons for personal care of the throat and nose, avoidance of too intimate contact with others, and the necessity of early preventive measures in the case of those suffering from "sore-throat" and lesions suspicious of diphtheria.

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This journal endeavors to mirror the progress of the profession of California and Arizona.

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EDITORIAL

OUR FORTHCOMING SERIES OF ARTICLES.

The interest being manifested in our announcement last month that we proposed publishing a series of practical articles by Dr. Henry R. Harrower on "The Diagnosis of the Internal Secretary Disorders" to start in our May issue, is as encouraging as it is surprising. Evidently the profession is very much awake to the growing importance of the glands of internal secretion in every-day practice.

The manuscript for several of the papers is already in hand and some of it is in type. It is excellent and we are enthusiastic about it. The subjects are interesting and practical, the writer's style is pleasing and between the lines we can see an enthusiasm which we are sure will infect those who "read, mark and inwardly digest" Doctor Harrower's articles.

The title of the first paper which will appear in our next issue is "The Fre-

quency of Internal Secretary Disorders in Every-day Practice," and it emphasizes the insidiousness of these disturbances and their intimacy with many well-known conditions. As Doctor Harrower says: "Too often we are prone to look upon this class of cases as rare and occasional, and their diagnosis as comparatively easy because of the obviousness of such diseases as cretinism, myxedema, giantism or acromegaly. This is a mistake, for functional disorders of this class are of every-day occurrence and are far more important than the more obvious organic diseases for they are still in their early stages before serious disharmony is caused and are naturally more responsive to suitable treatment."

The next two papers (for June and July) take up the disorders of the thyroid apparatus, the first one being "The Detection of the Minor Thyroid Dyscrasias," and the second, "The More Serious, Organic Thyroid Dis-

eases." These are important papers for when the thyroid is better understood it will be surprising how many times it enters into and complicates the commonest clinical disorders.

You cannot afford to miss one article in this excellent series.

THE PROCTOLOGIST AND GASTRO-ENTEROLOGIST.

The American Journal of Gastroenterology has combined with The Proctologist and hereafter will be published (beginning with the March number, first of year) as The Proctologist and Gastroenterologist, from St. Louis. Dr. Lewis Brinton, Philadelphia, and Dr. Anthony Bassler, New York, will have editorial charge of Gastroenterology; Dr. A. L. Benedict, Buffalo, editor of Dietetics; Dr. Rollin H. Barnes, St. Louis, will be managing editor and publisher.

HONOR OF MEDICAL MEN.

An eastern medical journal contains editorial notice of thievery and attempted thievery by hospital internes, especially upon leaving the institutions with which they have been connected. Our experience with the medical profession would seem to indicate the possibility that the tendency to thievery and dishonesty does not terminate when some medical men enter independent practice. Among the most despicable acts that dishonor the profession of medicine are the petty larcenies or attempts at petty larceny of those who subscribe for and receive a medical journal, with the current bills, and then refuse to pay. We have been intending for some time to publish a list of these professional pests, but have been delaying until we can arrange with the other American medical journals to do likewise. Every one of them ought to be sued for receiving goods under false pretenses. Such villainy is altogether loathsome to the honorable members of our profession.

HISTORY OF BILL ON CRIMINOLOGY.

The Bill on Criminology (S. 4990 and H. R. 8820) has been introduced in the present Congress by Hon. Joseph T. Robinson of the Senate, and Hon. Joseph Taggart of the House. It is one of the oldest bills in Congress. It has been reported favorably by the Judiciary Committees of both houses twice. It has failed to become law mainly through unintentional delay.

The bill has been endorsed by the principal representatives of the legal and medical professions of this country, including the American Bar Association and six National and twenty-five State medical societies; it has also been recommended by many religious associations of different denominations, including twenty-five Presbyteries. It also has the endorsement of the Congress of Criminal Anthropology in Europe. No bill ever in Congress has had such endorsement. The plan of work in bill was presented to Russia and Belgium, and adopted by both countries. Many other foreign nations are doing scientific work in criminology.

Purpose of Bill on Criminology.

The general purpose of the bill is to lessen and prevent crime, pauperism and defectiveness by the best methods known to science and sociology. In addition to this general scope of the bill, there are some direct ends in view:—

1. To gain more trustworthy knowledge of social evils. Such knowledge would furnish a basis for modifying defective laws, adapting them to present conditions.

2. To furnish a basis for methods of reform, and in addition seek, through knowledge gained by scientific study, to protect the weak (especially the young) in advance BEFORE they have gone wrong, and not AFTER they have fallen and become tainted, which is the great defect of most schemes of reform.

3. To find whether or not there are any physical and mental characteristics

that distinguish habitual from occasional criminals. Such knowledge would enable the community to protect itself in advance from habitual criminals and assist prison officials in preventing them from contaminating other criminals.

4. Exhaustive study of single typical criminals, which represent a large number, will give definite knowledge as to just how men become criminals and to what extent their surroundings influence them as compared with their inward natures. This would make possible a rational application of remedies for these evils.

5. More exact knowledge of the abnormal classes will enable us to manage them better in institutions. Such studies will bring men of better education and training in control of the institutions, and increase interest in the PROFESSIONAL study of these classes, which the American Bar Association emphasized, when endorsing the work.

6. To summarize and combine results already gathered by City, State and Federal institutions and governments, encouraging uniformity of method in collecting data and making such data useful generally.

7. To lessen the enormous expense to governments of the abnormal classes by study of the CAUSES of the evils that involve such expense.

One reason why so many professional organizations dealing first hand with some phase of this work support this measure is that they think it is time that governments begin a scientific study of those social evils which are their greatest enemies. Many worthy efforts are being made to lessen social evils, but they are mostly palliative, and do not go to the root of the matter.

Show your interest in a practical way, by writing your Senators and Representatives at Washington, urging their support of this measure.

THE FIRST MEETING OF THE PACIFIC DIVISION OF THE AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE.

During the past year a general association of scientific interests on the Pacific Coast supported by affiliations with a number of Pacific Coast scientific societies has been effected under the auspices of the Pacific Division of the American Association for the Advancement of Science.

The first meeting of this division has been appointed for San Diego between the dates August 9th and 12th, 1916. This will be an event of especial significance to western scientists because it will be the first of a series of similar meetings which it is planned to hold annually in the various educational centers of the Coast, and because it occurs in a region which presents many interesting features of geology, archaeology, botany and zoology.

The organization of a Pacific Division of the American Association is more-over a distinct recognition of the attainments of western scientists and research institutions. The American Association is an organization of nearly seventy years' standing and is the largest general scientific organization in America. Its purposes are to encourage and assist work in any field of science, and also to make the achievements of science more readily accessible and intelligible to people in general.

The officers and members of the Executive Committee in whose hands are the general plans for the San Diego meeting are representative of several branches of science.

President, W. W. Campbell, Lick Observatory, Mount Hamilton, California.

Vice-President, D. T. MacDougal, Desert Botanical Laboratory, Tucson, Arizona.

Secretary-Treasurer, Albert L. Barrows, University of California, Berkeley.

Executive Committee.

D. T. MacDougal, Chairman, Desert Botanical Laboratory, Tucson, Arizona.

W. W. Campbell, ex-officio, Lick Observatory, Mount Hamilton, California.

Edward C. Franklin, Stanford University, California.

Theodore C. Frye, University of Washington, Seattle.

C. E. Grunsky, San Francisco, California.

George E. Hale, Mount Wilson Solar Observatory, Pasadena, California.

Vernon L. Kellogg, Stanford University, California.

A. C. Lawson, University of California, Berkeley.

E. P. Lewis, University of California, Berkeley.

Among the important addresses to be given at the San Diego meeting of the Pacific Division of the American Association will be that of the President of the Division, Dr. W. W. Campbell, Director of the Lick Observatory of the University of California, Mount Hamilton, entitled, "What We Know About Comets." Two other general addresses will be given by Dr. F. F. Westbrook, President of the University of British Columbia, by Dr. Barton W. Evermann, Director of the Museum of the California Academy of Science.

San Diego as a meeting place will be especially attractive to scientists this summer because of the exhibits of scientific materials at the Panama-California International Exposition including an unusually complete series illustrating the history of man. Added interest is given to this period by the Assembly in Science at the Scripps Institution for Biological Research at La Jolla near San Diego, extending from June 26th to August 5th in the nature of summer school at this seaside laboratory. Two other marine laboratories in Southern California will be open throughout the summer, that of the University of Southern California at Venice and that of Pomona College at Laguna Beach. At Pacific Grove the Stanford Marine Laboratory will be open for a summer session of six weeks beginning May 22nd.

Southern California is of especial interest because of the natural features of geology, zoology, botany, and of the

archaeology of the Southwest, which are peculiar to the region. Many of these are readily accessible from San Diego, and excursions to them will form a prominent part of the San Diego meeting of the Pacific Division of the American Association for the Advancement of Science, in August.

OUR COLLEGES.

The Journal of the American Medical Association—date of April 8—gives an interesting resume of the work of the medical colleges of the United States. It shows that the college of Physicians and Surgeons of the University of Southern California has had 31 examined during the year. Of these, 28 were examined in California; 25 passed and 3 failed. One was examined in Arizona and passed. One was examined in the state of Washington and passed. One was examined in West Virginia and passed. In Leland Stanford University there were 14 examined in California, and all passed. And there were none examined in any other states. In the University of California medical schools there were 14 examined in California, and 14 passed; and none examined in any other state. This certainly is a very creditable showing for all of our leading California medical schools.

Poor Santa Barbara has no place for tuberculosis, save the county hospital. The proposed sanitarium in the Santa Ynez mountains has failed to materialize because of lack of capital. Almost as bad as the city of Los Angeles, where the patient with tuberculosis must go outside of the city to receive hospital or sanitarium care, owing to the foolish action of a weak-kneed council dominated by terror-stricken cranks. Such is some of our modern civilization.

EDITORIAL NOTES

A Los Angeles man, one of our recent acquisitions, submitted a prize-winning essay on "The Treatment of Rickets" to our contemporary the New York Medical Journal. (April 1, 1916.) We congratulate Dr. Henry R. Harrower upon his article as well as the \$25 prize which it has won for him.

Dr. L. P. Kaull, who was one of the prominent surgeons of Los Angeles, has succeeded Dr. A. J. Murietta as head surgeon for the United Verde Copper Co. at Jerome, Ariz. The doctor is an able man, and we regret to lose him. Young men desiring to get located in Arizona might do well to correspond with Dr. Kaull.

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ment \$60,000. Very complete new building, never occupied. Includes latest hydrotherapeutic equipment in connection. Great bargain and favorable terms to right party. Address Secretary, P. O. Box 476, Los Angeles, California.—(Adv.)

A good practice without cost may be had at Long Beach or Los Angeles by well qualified man of good appearance who is willing and able to work hard; prefer man under 50 years of age, with some surgical ability, automobile advantageous out not absolutely necessary. In replying please state age, school, experience, whether married or single, and last place of practice, and whether you prefer Long Beach or Los Angeles. Address 10739, care of the Southern California Practitioner.—(Adv.)

BOOK REVIEWS

INTERNATIONAL CLINICS. A quarterly of illustrated clinical lectures and especially prepared original articles on treatment, medicine, surgery, neurology, paediatrics, obstetrics, gynecology, orthopedics, pathology, dermatology, ophthalmology, otology, rhinology, laryngology, hygiene, and other topics of interest to students and practitioners. By leading members of the profession throughout the world. Edited by H. R. M. Landis, M.D., Philadelphia, with the collaboration of Charles H. Mayo, Rochester; Sir Wm. Osler, M.D., Oxford; Rupert Blue, M.D., D.P.H., Washington, D. C.; A. McPhedran, M.D., Toronto; Frank Billings, M.D., Chicago; John G. Clark, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harold, M.D., London, and Richard Kretz, M.D., Vienna. With regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipsic, Brussels, and Geneva. Volume I, Twenty sixth Series, 1916. Philadelphia and London: J. B. Lippincott Co. Price \$2.00.

An important feature in this volume is a General Review of Medicine for 1915, by Frank A. Craig, M.D., and John Speese, M.D., covering 110 pages. It is a good review and well written.

There is a very practical article on Chorea: Including a New Treatment, by Edward E. Mayer, M.D., and W. H. Mayer, M.D. These writers believe the streptococcus viridans is the specific cause of chorea, and their results in the serum treatment of chorea would seem to lend support to that view.

Drug Therapy in Cardiovascular Disease is presented by Thomas E. Satterthwaite, M.D., LL. D., Sc.D., of New York. Discussing the various vasomotor drugs, the writer has the following to say regarding cactus, the *Cereus grandiflorus*, or night-blooming cereus of Mexico: "I am aware that experimentation on animals has been used to prove that cactus is inert, whether given by the mouth or vein, but on this point clinical experience appears to have demonstrated its utility." It would seem that this is only another

illustration of the fact that should be more generally recognized, that we should be cautious when it comes to permitting animal experimentation to take precedence over rational clinical experience.

THE CLINICS OF JOHN B. MURPHY, M.D., at Mercy Hospital, Chicago. Volume V, Number 1 (February, 1916). Octavo of 194 pages, 33 illustrations. Philadelphia and London: W. B. Saunders Company, 1916. Published Bimonthly. Price per year: Paper, \$8.00. Cloth, \$12.00.

When you fully realize that truth is often stranger than fiction, you are inclined to form a different conception of romance from that commonly held. Romance is somewhat limited, inasmuch as it is essential that situations and incidents should be plausible. It is possibly these limitations that restrain us from using the term in connection with Murphy's Clinics, which hold and excite the imagination like a romance, but deal with situations and incidents as strange as the truth, in the wizardry of surgery.

SOCIAL TRAVESTIES AND WHAT THEY COST. By D. T. Atkinson, M.D. New York: Vail-Ballou Company, Publishers.

Dr. Atkinson, who is a practitioner in Dallas, Texas, has written under the above title a book that will stimulate thought. It is quite time that the sex and venereal problems were treated in a rational manner.

GOULD'S PRACTITIONER'S MEDICAL DICTIONARY. Third Edition, Revised and Edited by R. J. E. Scott, M.A., B.C.L., M.D., of New York. XX+962 pages. Flexible Cloth, Round Corners, Marbled Edges. P. Blakiston's Son & Co. \$2.75.

This new edition of "Gould's Practitioner's Medical Dictionary" provides a modern dictionary for physicians and medical students, that is up-to-date. It contains all the words that are needed, is issued in a form convenient to handle, and is published at a low price. The type throughout has been reset.

Among the newer words are: endocrinology, endocrinous, endocrinic, and endoeritic. This is a worthy member of the esteemed family of Gould medical dictionaries.

The Martin H. Smith Company has removed to 150-156 Lafayette Street, New York.

Mr. William Price Hagee, president of the Katharmon Chemical Company, passed away February 3rd, 1916.

The Chicago Medical Society announces the fifth annual meeting of the Alienists and Neurologists of the United States to be held under the auspices of the Chicago Medical Society, June 19-23, 1916, at LaSalle Hotel.

Mr. E. W. Thurston has been appointed manager of the Off & Vaughn Drug Company. This establishment is constantly improving its equipment and has maintained an excellent reputation for thirty years.

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SOUTHERN CALIFORNIA PRACTITIONER

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THE DIAGNOSIS OF THE INTERNAL SECRETORY DISORDERS.

BY HENRY R. HARROWER, M.D., F.R.S.M. (LOND.), LOS ANGELES, CAL.

I.

Preliminary Considerations: The Frequency of Internal Secretory Disorders in General Practice.

The insidiousness and practical importance of disturbed function of the glands of internal secretion is far greater than most physicians realize; and the frequency with which it may be encountered in almost every phase of general as well as special practice, coupled with the fact that many times it is entirely overlooked, constitute the excuse for this series of articles.

Increasing attention is being paid to the study of the glands of internal secretion, or **endocrinous organs**, as we shall call them, and rightly so. Our knowledge of the physiological action of these organs has been acquired almost entirely in the last fifty years; and has been augmented very materially in the past 15 or 20 years. In fact practically all we know of the internal secretions has been learned in this brief period and the establishment of the fundamental conceptions of the now famous Claude Bernard and Brown-Sequard was not accomplished and their experiences scientifically explained until as recently as 1902,

when Starling, of London, suggested the term "hormone" (from the Greek word which means "I arouse" or "I set in motion") to designate a class of chemical substances, of which his newly discovered secretin was the type, which are produced in various parts of the body and carried by the blood or other body fluids to various remote organs where they excite certain physiological manifestations, thus correlating the functions of numerous and widely separated organs.

The subject is of much more than academic importance for "treatment based on the internal secretions is, in some instances, positively startling in its results, and bids fair to revolutionize our methods in several lines of practice; it is also eminently satisfying from a scientific viewpoint, being far removed from our old hesitating empiricism".*

The endocrinous glands, then, are factors of no mean import in the maintenance

*Editorial in the New York Medical Journal, Feb. 26, 1916, p. 412.

nance of that balance of activities which we usually call "health", and hence are worthy of more careful study and practical consideration in our clinical work. These organs and their hormones play a much more vital part than many physicians have allowed themselves to think. Variations in their activities deserve the closest attention, for too often endocrinous disorder is only thought of when there is obvious disease of one or more of these glands. Since they are now definitely known to control growth and development, regulate metabolism and dominate the nervous system, more especially the sympathetic or autonomous system, their wide-spread activities assume a greater importance for it is quite clear that these hormones are altogether indispensable to the maintenance of the physiological harmony of the body.

Too often we are prone to look upon this class of disorders as rare and occasional and their diagnosis as comparatively easy because of the obviousness of such well-marked diseases as cretinism, myxedema, giantism or acromegaly. This is a mistake, for functional disorders of this class are of everyday occurrence and are naturally far more important than the more obvious organic diseases, for they are still in their earliest stages before serious disharmony has been caused; and, of course, are more responsive to suitable treatment.

Such all-essential factors in the regulation of human chemistry should be of interest to every general practitioner in his investigation of **every** condition in which disordered function is present. We should not be satisfied to know how to diagnose and treat those definite cases of definite endocrinous disease, but rather should we be always on the lookout to detect and understand the importance of the insignificant and minor aberrations from the normal, for in so doing in many a case we may be able to forestall the more serious and more obvious diseases which, if left alone, may later assert themselves.

As the larger functions of the internal

secretions are being appreciated, their influence both for good and for bad is seen to extend far beyond the expected limits of definite endocrinous disease, for as one writer has aptly put it: "There are a number and variety of conditions which can be understood and properly treated only after full comprehension of the work of the endocrinous glands." All the uncounted clinical and experiential experiences which have been directed as the solution of the numerous problems which this ever-broadening subject has opened up, have convincingly demonstrated that the influence of the various units of the endocrinous system as well as of the system as a whole, is far more extensive and complex than even the best-posted physiologists had supposed, and that many phenomena credited to nervous or sympathetic nervous influences were really the result of hormonal disharmony. In fact we know as a result of the painstaking work of Cannon, Crile, Elliot and Sergent, that as the sympathetic system is under the direct control of one or more of these hormone influences, disorders with prominent sympathetic disturbances, as shock collapse, hysteria and other neuroses may be traced further back than we have been in the habit of doing heretofore and what is of far greater practical importance, may be controlled by applying the principles which the study of this subject simultaneously has proved possible in the domain of therapeutics. Crile's exhaustive study of the kinetic system—the adrenals, thyroid, brain and muscles—and its practical application in what he chooses to call "anoci-association", is but one of many profitable phases of this huge subject, a part of which it is proposed to consider in this series.

Now that the interest of the aggressive section of the profession is being focused upon these endocrinous glands, and much regarding their study and the importance of the many phases of the subject is appearing in current medical literature a comparatively new branch of medicine

is gradually being differentiated, and with the better knowledge that we have of the physiology of the hormone-producing organs, there comes not merely an increased diagnostic skill, but a broadened therapeutic horizon, for in the study of the internal secretions lies the future of the treatment of most functional disorders. To tell the truth the extensive ramifications of this subject and the increasing prominence of the endocrinous features in so many minor as well as important disorders, is awakening an interest in a new specialty which Sajous has recently called "**Hemadenology**" (blood—gland—discourse) and which the writer prefers to designate "**ENDOCRINOLOGY**" (internal—secretion—discourse). As Sajous says, this branch of medicine "claims the right to exist as a specialty for its field is greater in scope than some which have earned well merited recognition."* Sajous then continues: "Its influence on the improvement of the race through the light it will shed upon the pathology of the unfit, mental and physical, cannot but prove a blessing. If to this we add the many disorders it will serve to elucidate through collective effort on the part of the host of investigators it is bound to enlist . . . the day may come when the inauguration of hemadenology may be considered as having marked a new epoch in medicine."

All who have studied this subject admit that it has a fascination that cannot be measured. The profitable applications that have been made in clinical practice by the employment of organotherapy, or "hormone therapy", explain in a good measure the favor with which this subject is being received by the medical world.

As we occupy ourselves in searching for the earliest signs of endocrinous disorder, automatically we gain a better insight into the intricacies of the functions of the body and are not merely able to

forestall the later and more serious organic disease, but so often we run across associated manifestations of the most diversified kinds, from nocturnal enuresis to chilblains or from neurasthenia to a stiff neck, which may be modified directly by suitable organotherapeutic measures which we may be directing at an associated but entirely different condition.

None can deny that a knowledge of these twin subjects—endocrinology and hormone therapy—has put an entirely new aspect on the outcome of many intractable disorders. The increasing appreciation of the role of the endocrinous glands has, as Leonard Williams has said, "lightened our darkneses and shown us miracles." What other word than "miracle" can be applied to the startling effects of thyroid feeding upon the pitiful conditions of cretinism? How many of the "darkneses" of practical medicine are being illuminated by what science has taught us regarding the hormones in physiology and therapeutics, may be more evident as this series unfolds.

In the words of an editorial writer in **American Medicine**:* "Many a chronic and intractable disorder is due to an overlooked defect in the production of the hormones of the internal secretory glands. Increasingly greater stress is being laid upon the importance of these chemical messengers, and there is now little doubt that in health as well as in disease, they regulate and correlate the metabolic activities of the body." Again the importance of this is emphasized in a recent review in the **Lancet**† from which we quote: "As our knowledge has progressed, the influence of the ductless glandular system has proved to be far wider and more penetrating than any of the earlier investigators suspected. It controls growth and metabolism and in short, determines largely the nature of that factor which the older physicians spoke of as 'constitution'."

*C. E. deM. Sajous, "Hemadenology: A New Specialty," New York Medical Journal, Feb. 20, 1915, p. 365.

*Editorial in *American Medicine*, Aug., 1915, p. 590.

†Book review in the *Lancet*, Dec. 11, 1915, p. 1301.

The internal secretions have revolutionized physiology and with it clinical medicine, just as hormone therapy has revolutionized certain phases of treatment; hence the general practitioner, above all others, stands to benefit by this added fund of knowledge. As we become better acquainted with the endocrinous disorders it will be noticed that intimations of their presence are staring at us in every turn in our daily routine; and we will find many an occasion to congratulate ourselves that we have taken time to investigate this fascinating and interesting subject.

EDITOR'S NOTE: As Dr. Harrower says this is still somewhat of a "new" subject, and it is quite likely that the

Southern California Practitioner can serve its readers to better advantage by offering them more direct personal information. So we have arranged to conduct a correspondence clinic for the benefit of our readers, in which cases of definite or fancied endocrinous disorder may be considered and suggestions made regarding their care. To avoid unnecessary inconvenience and delay it is requested that (1) Only one case be mentioned in a letter, (2) the clinical data be as concise and complete as possible, (3) communications be written on one side of the paper and that (4) two 2-cent stamps be enclosed—for forwarding the letter and the answer. Inquirers will hear direct from Dr. Harrower and several of these "Clinics" will be printed following each installment of this series. It is believed that this feature alone will multiply the very obvious value that a series of this character, on so important and little appreciated a subject, can be to those who follow it from month to month. Address all communications to "Clinic" in care of the Southern California Practitioner. In June "The Detection of the Minor Thyroid Dyscrasias."

INDICATIONS AND CONTRA - INDICATIONS FOR MASTOID OPERATION.*

BY DR. GEO. W. McCOY, LOS ANGELES.

There are too many preventable deaths from mastoiditis and its complications in Southern California. The Eye and Ear Section of the Los Angeles County Medical Society once a year sets aside a meeting at which the deaths for the past twelve months are reported, of which last report over 90% of deaths were due to suppuration of the ear. Too late with operative interference almost always is the fatal mistake.

In the hands of a skilled aural surgeon and barring those cases of mastoiditis associated with some other serious disease of the body which might make operation inadvisable, and barring those extremely rare cases of such virulent infection of the middle ear that in a few hours a fatal complication has occurred, the death rate of mastoiditis is practically nil, providing of course he has charge of the case before some fatal complication has set in. The delay in operation has a very good excuse, however.

Accepting the often repeated theory that practically in every severe purulent

inflammation of the middle ear the antrum or some mastoid cells are involved it follows that less than one per cent of mastoiditis requires the mastoid operation. The laity by their experience in having seen so many cases of a running ear get well with little or no treatment the profession in general having had scores of cases completely recover; some specialists who boast of having cured so many cases without operation; these overwhelming experiences in favor of recovery without the mastoid operation beget a confidence that leads in some cases to fatal delay.

In some cases for a time it is impossible even for the very elect to determine whether recovery will ensue without operation or whether the next day fatal symptoms will develop. In some cases dangerous complications by blood vessels or lymphatics may occur without any clinical symptoms of mastoiditis and without finding any pus in the mastoid cells at operation. There may be merely slight continual indisposition of the pa-

*Read before the Southern California Medical Society, May 4, 1916.

tient, hardly able to be up and around. The leucocyte and blood count show pus, or the lumbar puncture shows inflammation of the lateral sinus or the entire symptoms slowly point to brain abscess. These are the unusual symptoms of complication. Usually thrombosis of the lateral sinus is attended by chills or chilly sensation, the fever is hectic, may or may not come to normal but suddenly reaching 104° or more, markedly irregular, the leucocyte count is high, the differential points to pus, lumbar puncture may show an altered fluid. The symptoms of brain abscess and meningitis are to be carefully watched for. If in mastoiditis complications are suspected, operation is imperative.

In such cases all resources must be fully and exactly ascertained by men able to do exact work—the laboratory reports and the clinical aspects duly considered, the entire system of the patient carefully examined that a tubercular hip, rectal abscess, or some other hidden affection might not be the real cause of the patient's condition. By such procedure all will agree our best surgical judgment is obtained.

In theory the judgment of aural surgeons is the same—never to operate unless compelled to do so; but in practice some operate earlier than others. In these **doubtful** cases after a reasonable time in treatment following an early and free incision of the drum the surgeon who operates earlier will have for his results the following:

1. Having operated on more cases that would have recovered without an operation than those who operate later.
2. A less percentage of deaths.
3. Better hearing because it is well established the longer the suppuration the greater damage to the sound conducting apparatus.
4. A less percentage of chronic running ears.

The surgeon who operates later will have

1. A greater percentage of cures without operation.

2. A greater percentage of deaths.

3. More impaired hearing in a series of cases.

4. A greater percentage of chronic running ears.

The statement is made by some authors that only a few cases of distinct purulent mastoiditis get entirely well without an operation. In my own practice I can present many cases of complete recovery and of perfect health.

After a free incision of the drum and night and day treatment for a time, if still in doubt I will operate if people will permit me, thereby having given the patient a reasonable period to get well without operative interference; by operating reasonably early removing the too great risk to life and preserving the hearing.

In acute cases sagging of the post-superior wall of the canal next to the drum is perhaps the most important single symptom. By a free incision of the drum and extending the incision to the bone along this sagging I have seen a few of these cases recover without the mastoid operation. Tenderness over the antrum, at the tip, or over the emissary vein is an important symptom, allowance being made for the readiness of some individuals to complain of pain at the slightest discomfort. Especially care must be exercised that an external otitis, especially boils, may not be the cause of oedema or tenderness back of the ear, the differential diagnosis of which in some cases is extremely difficult. In doubt treatment will clear the question in a short time.

Temperature because of its variation in different cases is of minor importance for diagnostic value.

Given a case of discharge from the ear with a free opening in the drum, sagging of the post superior wall, tenderness back of the ear, high or moderately high fever, with day and night treatment for a few days without symptoms becoming better, it is the duty of the physician to emphatically advise operation. Some cases

will get well without an operation but it is too dangerous to delay longer.

In chronic cases any of the following conditions will indicate the radical operation, (adapted from Politzer):—

Caries of temporal bone; recurring polypi in the tympanic cavity arising from the attic or antrum; fistulous openings on the mastoid process; cholesteatoma if treatment fails to cure; obstinate suppuration from the antrum of persistent treatment fails to cure; strictures of the external meatus which cannot be relieved; paresis or paralysis of facial nerve on a chronic running ear; intercurrent acute mastoiditis; foetid middle ear suppuration resisting long continued local treatment and the removal of ossicles; with any of these named conditions operation becomes imperative if associated with remittant septic or continuous fever and chills; vomiting with cerebral irritation and headache; papel-

lilis and choked disc; continuous or often recurring pains in ear or mastoid or headaches on same half of head; attacks of dizziness or continued dizziness and symptoms of secondary labyrinthine suppuration; at the last signs of cerebral irritation, severe headaches, nausea, vomiting.

In closing surely, surely, with the continual higher standard of admission into our medical schools and of higher requirements in our medical colleges themselves the medical profession will continue more emphatically to teach the laity that in a great percentage of ear affections the time to treat such conditions is before the ear is affected by putting and keeping the nose and throat in the best possible condition thereby saving so many cases from impaired hearing and from the occasional loss of life; and for the profession to clearly realize that poor work upon the nose and throat is worse than no work. Security Building.

DIAGNOSIS OF OSTEOMYELITIS.*

BY DR. W. W. RICHARDSON, LOS ANGELES.

Within a short period four children presenting a similar group of symptoms have come under my observation.

In case one—a boy of ten—the illness had begun a fortnight before, acutely, with high temperature, vomiting and early delirium. It was early noted that several joints were tender to touch and movement, though there was little or no swelling. The illness advanced rapidly, and the delirium progressed to unconsciousness. He was admitted with a diagnosis of typhoid fever and acute rheumatism.

The child appeared seriously ill. There were sordes upon the teeth and lips. He was unconscious with muttering delirium. The pupils were contracted. The neck was stiff. The pulse rapid and weak. His temperature 104°. Movements of the limbs elicited evidence of

pain but there was no swelling of the joints with the exception of the left knee which was somewhat enlarged. Here the tenderness was greatest. Especially deep pressure over the lower extremities of the femur aroused him from his coma to expressions of severe pain. A systolic murmur was heard over the cardiac area. The lung showed no evidence of disease. Some albumen was present in the urine.

The second case gave a very similar history but of shorter duration. There was the same acute onset with high temperature and early delirium. The same pain and tenderness of the joints appearing early. Upon admission, one week after the onset, one recognized at a glance a very ill child. The temperature and pulse were high. There was delirium at times but not unconsciousness. The right shoulder was greatly swollen, reddened and exquisitely tender to touch.

*Read before the Southern California Medical Society, May 4, 1916.

Again the diagnosis had been that of acute rheumatism.

The third case I saw in consultation at midnight. A child of five who had been taken suddenly ill about five days previously. The illness was characterized by high temperature, early delirium, and for the past twenty-four hours, gradually increasing unconsciousness. The mother stated that he early complained of pain upon movement of the right hip, which increased in severity, and upon the day I saw him a surgeon in consultation had pronounced the trouble acute synovitis of the hip and had put the limb in Buck's extension.

He was now in deep coma, with contracted pupils and rigid neck. There was a systolic murmur at the apex. The temperature and pulse were high. Inspection of the hip showed some swelling of the thigh. Movements of the limbs caused expressions of pain, and deep pressure over the upper third of the femur aroused him from his coma to cry out with pain.

Case four. A girl of five was admitted to the observation ward of the Los Angeles County Hospital on the night of April 5th.

She had been ill for six days with temperature and pain in the region of the left hip.

She was thought to have rheumatism. Her condition had grown steadily worse, and upon admission she was delirious with a temperature of 106°. I saw her on the following morning. She appeared very ill with a low muttering delirium. The pulse was rapid and weak. The temperature 104°. The left lower extremity was held rigidly in flexion and attempts to straighten it caused evidences of pain. Only by close comparison could swelling be detected in the region of the hip and upper thigh. There was no discoloration. Pressure along the upper half of the femur roused her to expressions of pain.

These four cases had then in common:

1. Sudden onset with high temperature and early delirium.
2. Early appearance of pain and ten-

derness in the neighborhood of the joints, especially of one joint.

3. Swelling and tenderness especially upon deep pressure over the extremity of one of the long bones.

A group of symptoms quite sufficient for a diagnosis, and yet not one of these cases had been recognized by the attending physician. In all a stage of profound intoxication had been reached, and although immediate operation gave exit in each case to pus from beneath the periosteum and from within the Medullary cavity of the bone, there was no improvement in the general condition and death resulted from septicaemia.

This type of acute osteomyelitis can be saved only by early diagnosis and early operation.

We cannot wait until the signs are so pronounced that "he who runs may read."

It is true that early the local signs are slight and easily overlooked, and that late they are masked by the benumbed consciousness, but they may be discovered if suspected and searched for. The most significant sign is that of pain upon deep and continued pressure along the shaft of the bone usually near the Epiphysis.

In the pronounced cases of acute multiple osteomyelitis, the swelling and tenderness of the joints leads to a diagnosis of acute rheumatism and the early appearance of profound sepsis, out of proportion to the local findings, suggests typhoid and the diagnosis of Typhoid Fever with acute Rheumatism is the one most frequently made. So true is this that such a diagnosis is recognized by our nurses as synonymous with Acute Multiple Osteomyelitis.

In no disease is an early diagnosis more important, nor prompt surgical intervention more necessary than in this one, and yet how rarely is it made.

Within the cancellous tissue of the extremity of the bone, surrounded by the unyielding cortex, the inflammatory action is taking place. There is no chance for relief of pressure by swelling. The

bacterial toxins under pressure are rapidly absorbed, and general septicaemia occurs with death before there has been time for necrosis to take place. Swelling is not evident until the periosteum has become involved by extension from the interior through the vessels piercing the cortex. Redness and superficial tenderness are not manifest until the infection having separated the periosteum from the bone over a considerable area have then broken through the periosteum and infiltrated the muscles and subcutaneous cellular tissue.

Even in this late stage the original seat of the infection is often overlooked and the abscess alone recognized. But now little harm is done by delay in opening such an abscess. The damage is done, the bone is dead, the disease has played itself out and the process of separation of the sequestrum and the formation of new bone the periosteum is but a process of repair. The surgeon can only assist, his time for prevention is passed.

It is in the incipency of the process when the infection is confined within the unyielding walls of the cortex, and by the pressure of the inflammatory products as well as by the direct action of the toxins is causing death of the bone, that prompt relief of this pressure will save the life of the patient by preventing

absorption and save the life of the bone by the relief of pressure.

In the great majority of cases these patients are seen by the surgeon only when the damage has been done. The superficial abscess has been lanced. The persistence of a sinus alone leads to the suspicion of deeper disease. There is now no hurry. Sufficient time must be allowed to lapse before operation for the removal of the sequestrum, in order that new bone may be formed of sufficient strength to maintain the continuity of the limb. We are here in danger of operating too early rather than too late, for the removal of the sequestrum if involving the entire thickness of the shaft of a long bone may lead to great deformity, while if allowed to remain it maintains the continuity of the limb and stimulates by its presence the formation of new bone. We have removed in these late operations the greater part of the shaft of the Femur, the Tibia, the Fibula and the Ulna with little resulting deformity.

My object in presenting this subject to you, is to recall to your minds the symptoms of that dread disease, Acute Osteomyelitis and to ask you to keep it in mind in every case of acute illness in childhood to which you may be called. If you are alive to its existence you cannot overlook it. Its early recognition may save a life or prevent a crippled existence.

CRANIAL INJURIES, PROGNOSIS AND TREATMENT.*

BY DR. E. H. WILEY, LOS ANGELES.

It should be thoroughly understood that skull fractures are important only in connection with injury to the brain by the fracturing force. Functionally the skull is purely a protection for the contained brain. To all intents the brain is fluid and to it may be applied the law of physics that force is transmitted through a fluid equally in all directions. As the skull is a closed box, any impact is transmitted to its contents. If the

force is not too great there results concussion characterized by unconsciousness, nausea and vomiting, without characteristic pulse disturbance as in compression, and without force symptoms.

The treatment may be dismissed with one word "rest". This quiet ought to be maintained several days. These cases recover with a loss of memory for events preceding the accident, which may be permanent. They also complain of dizzi-

*Read before the Southern California Medical Society, May 4, 1916.

ness and headache, sometimes for a long time after.

If the impact is more severe the skull bends to its limit of elasticity and then breaks. When it bends one diameter is shortened but another is increased. This means compression, contusion or laceration of the contained brain. Inasmuch as the base of the brain is more firmly fixed by the cranial nerves and by the dural attachments, it is here we find contusion and laceration most marked. I have never seen a postmortem of a basal fracture in which the base of the brain did not show marked softening or dural laceration.

Leaving aside the question of infection, the prognosis as to survival hinges entirely on the degree of damage inflicted upon the brain at the time of injury. There is, among the laity and perhaps to some extent amongst the profession, a tendency to magnify the importance of the injury to the skull. Extensive brain damage may be inflicted directly under the site of impact, with no evidence of bone injury other than a fissure. I have seen a flap of dura 3 inches by $\frac{1}{2}$ inch projecting from a fissure whose edges were nicely aligned. At the time of injury the edges were depressed lacerating the brain and later sprang back, with only a crack to show. On the other hand, extensive fragmentation of bone takes place with a minimum of brain injury.

We all know that depressed vault fractures offer brilliant results when the fragments are elevated or removed. This class of fractures is usually inflicted by some force operating over a small area so that the underlying skull is driven down without transmitting the violence through the whole cranial box. In other words—the fracturing force does not distort the diameters of the skull as a whole. Hence there is less general brain damage and a better outlook for recovery. Penetrating wounds by bullets are usually fatal on account of immediate damage to important centres or later from infection. When the general condition of the patients was good it has

been the practice at the Receiving Hospital to enlarge the wound of entrance, remove spicules of bone, infectious material and lacerated brain and to pack the wound lightly with iodoform gauze. A number of surprising recoveries have resulted even with the bullet still imbedded in the brain.

Several cases of compound fractures of the skull with very marked loss of brain substance, not involving the motor areas, have recovered. One man who collided with an auto while he was riding a motorcycle was struck in the right temporal region by a projecting part of the machine which crushed the squamous portion of the right temporal, penetrated the base so that the finger could be passed entirely through the skull and into the pterygoid fossa. The temporal sphenoidal lobe was terribly lacerated. In spite of this enormous loss of substance he recovered without paralysis, but with great interference to memory centres. He died a year later with appendicitis.

Basal fractures are most interesting from a standpoint of prognosis and treatment. There seems to be little definite idea of the percentage of recoveries. Before we can arrive at this result it is necessary to take up the diagnosis of the condition.

The cranial base is divided by bony landmarks into three fossae, anterior, middle and posterior. Fractures may involve one or more of these divisions. Aside from the clinical symptoms of brain injury the crack in the base is accompanied by hemorrhage. The blood seeps along the line of least resistance and makes its appearance at the surface.

If the injury is in the anterior fossa it opens the roof of one or both orbits. There follows a black eye, the discoloration being limited on the lids by the insertion of the orbicularis oculi. This is a discoloration following the contour of the orbit above, and leaving a white rim at the lid's edge. Appearing some time after the injury, and without contusion of the eye itself, it is diagnostic. If the fissure in the bone involves the cribri-

form plate of the ethmoid there will be epistaxis.

In the middle fossa the petrous part of the temporal suffers, with hemorrhage from the ear. In the posterior fossa base of the sphenoid or the portion of the occipital bone back of the pharynx will be involved. The blood flows into the throat and is subsequently vomited. Bloody vomitus following a skull injury without injury to the mouth is very suggestive of a fracture in this situation. Fractures of the posterior fossa, laterally, are evidenced 24 or 48 hours after the injury by the appearance of ecchymoses in the neck in the neighborhood of the mastoid process. They appear late because the effused blood has to travel a considerable distance to reach the surface.

The records of 129 skull fractures, exclusive of gunshot injuries, which passed through the Receiving Hospital in the sixteen months following January 1st, 1915, show 16 deaths, or 12 4-10 per cent, within 12 hours of injury.

Following the subsequent course of 50 basal fractures it appears that there were 18 deaths, or 36%. This is a considerably smaller proportion than the common estimate, but I believe it is quite accurate.

Naturally, the surgeon thinks what percentage of these 18 cases could have been saved by operation. As a matter of fact, 7 were decompressed with three recoveries and four deaths.

The one indication for operation is compression. If the symptoms in basal fracture are due to compression we should operate. If they are suffering from the effects of contusion and laceration operation is contraindicated. In the vast majority of cases the trouble is due to the latter cause and no operative procedure will alleviate the symptoms. The most valuable guide to the presence or development of compression is the eye grounds. Choked discs appearing after a skull injury indicate pressure and repeated examinations ought to afford valuable aid in reaching a decision.

Clinically, the following points have been of value in establishing operative indications.

First. Coma appearing after a period of consciousness or increasing after semi-consciousness: Second—Slow pulse. Third—spasticity of the limbs. Fourth—Transient or incomplete paralysis of one or more extremity.

Craniotomy usually shows no massive hemorrhage but a non-pulsating dura under great pressure. Opening the dura relieves the symptoms and in a few instances has, I believe, resulted in saving the patient's life. Probably the 14% of operative cases out of the 50, covers pretty accurately the number in which any such indication existed. When you consider that 57% of these died it is apparent that surgery will not accomplish very brilliant results in these injuries.

What is the prognosis as to the restoration of function of the 64% who survive the initial injury? While I have been unable to follow all of these cases closely I know the following resultant conditions.

Two cases of epilepsy appearing ten months to a year later.

One ocular paralysis.

One optic neuritis with fair recovery.

Several cases of impaired memory.

Several in which the mental status was changed, the patients being more irritable than before the injury.

Several cases of persistent dizziness and headache.

It is worthy of note that the majority of recovered cases left the hospital after varying periods with pulses appreciably slower than normal.

In conclusion—

1. 60 to 65% of basal fractures survive.

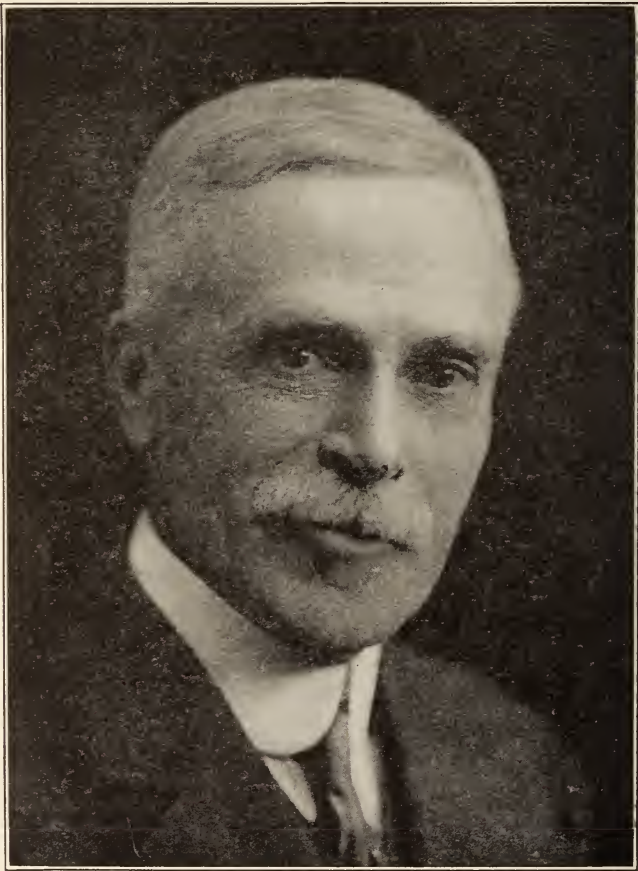
2. Not over 15% of basal fractures are operative.

3. A considerable per cent—25 to 50—suffer permanent changes as a result of cranial injuries.

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EDITORIAL

DR. ELBERT WING.

The death of Dr. Elbert Wing, on May 8, 1916, at his residence in Los Angeles, was a shock to his many friends in the profession.

Dr. Wing was born in Collinsville, Ill., October 3rd, 1852.

He received the degree of A. B. and A. M., from the Illinois college. After receiving his medical degree at the Northwestern University Medical School, in 1882, he was interne at the Cook County Hospital. After that he spent two years in post-graduate work in Berlin, Vienna and Prague, following which he practised medicine in Chicago for seventeen years.

During this time he was connected with the faculty of his Alma Mater, first as demonstrator of Pathology and then for several years as Professor of Nerve and Mental diseases:

He came to Los Angeles in 1902, where he lived a quiet, useful, professional life.

During his later years, he was neurologist for the Santa Fe Railroad, and

always commanded the highest esteem of his professional fellows.

He has been especially active during these years in the civic life of Los Angeles devoting much of his time generously to this work.

Dr. and Mrs. Wing have always been popular and much beloved in the best social circles.

His was, indeed, an ideal character, and his passing on is a distinct loss to Southern California.

STATE SOCIETY MEETING.

The committee of Arrangements did its work more than well and Fresno hospitality was much in evidence at the meeting of the State society. We may well be proud of the profession of Fresno.

Three days proved inadequate for the satisfactory presentation of the pent up erudition of two years accumulation. The papers were limited to fifteen minutes and the discussions to five minutes, and these measures were absolutely nec-

essary in order to complete the program in the allotted time. With the excellent material at its disposal, the committee on scientific program could have made good use of an additional day. Excessive verbosity is not desirable, nor is undue curtailment of papers and discussions conducive to the highest grade of scientific work.

Four excellent symposiums were presented, the first on exophthalmic goitre, the second on tumors of the kidney, the third on meningitis, and the fourth on focal infections. There was a decided paucity of papers on gynecology, there being only one paper within the sphere of that specialty. There were no papers on obstetrical subjects. The Eye, Ear, Nose and Throat Section and the Section on Genito-urinary Diseases did good work. It is to be hoped that the proposed Section on Surgery, Gynecology and Obstetrics will be speedily organized. The existing sections tend to create a false impression as to the class of medical practice that predominates in California.

Dr. George H. Kress was elected President, and with this selection there was very general satisfaction, the feeling prevailing that it is an honor worthily

bestowed upon one justly entitled to the distinction through long continued and able devotion to the welfare of the association. The next meeting is to be held at the Hotel Coronado, San Diego.

SOUTHERN CALIFORNIA MEDICAL SOCIETY.

The fifty-fourth regular semi-annual meeting of the Southern California Medical Society was held at Pomona, May third and fourth. The scientific program was very satisfactory, the papers and discussions being excellent. The program was full, but there was no undue rush, the various subjects being quite thoroughly discussed. There is a spirit of camaraderie in these meetings that is most delightful. The second day of the meeting was marked by a luncheon in Ganesha Park, the Society being the guests of the Pomona Valley Medical Society, and the afternoon session was held under the trees of the park, where provision has been made for holding such gatherings. The officers and entertainment committee are to be congratulated upon a two days' session that could scarcely be surpassed in profit and pleasure to those that attended in a receptive mood.

EDITORIAL NOTES

Typhus is reported raging in northern Mexico.

Dr. W. M. Kendall has been reappointed health officer of Venice.

Dr. Lewis A. Aarons, formerly of New York, has located in Fruitvale.

Dr. L. E. Lepper, of Pomona, is east for two months doing post-graduate work.

The Mechanism of Urination is the subject of a reprint by Dr. Arthur B. Cecil.

Dr. Edwin O. Palmer has installed an X-ray plant in his laboratory, in Hollywood.

Dr. Charles Eaton Phillips is now located in the Brack Shops Building, 527 W. 7th St.

Sinus Thrombosis in Compression is the title of a reprint by Dr. Cecil E. Reynolds of Los Angeles.

Supra-Public Prostatectomy is the title of an instructive reprint by Dr. H. W. Mills of San Bernardino.

We are glad to note that Dr. J. L. Pomeroy is convalescing from his operation for appendicitis.

Dr. John W. Flynn, of Prescott, has been elected President of the Arizona

Society for the Study and Prevention of Tuberculosis.

Wanted: An elderly person or invalid to board and care for in a private home at 1440 Malvern Ave., Los Angeles, Phone 24588.

Dr. W. B. Smith of Los Angeles has formed a partnership with Dr. Hoag and will build an office back of Glanville's drug store at Randsburg.

We have received an illuminating booklet: *Clinical Symptoms and Physical Signs in the Early Diagnosis of Pulmonary Tuberculosis* by Dr. F. M. Pottinger.

A communication from the Welfare Conference, San Pedro, asking that a clinic be established at San Pedro, has been referred to the Health Commissioner.

Dr. Edith Strong has been chosen bacteriologist for the health board of Santa Barbara. The equipment for the laboratory will be placed in the Cottage hospital.

The Los Angeles City Council has passed a resolution urging the County Supervisors to establish a smallpox hospital. Isn't the City smallpox hospital large enough for the entire county?

Dr. James H. McBride, of Pasadena, at the age of 67 years, has been granted permission to enroll for the military camp for civilians to be held at Monterey in July and August. How old are you?

Dr. A. J. Murrieta formerly Chief Surgeon for United Verde Copper Company, Jerome, Arizona has resumed the general practice of Surgery with offices in Suite 611 Brockman Building, Los Angeles.

Articles of incorporation have been filed by the County Hospital and Sanitarium Company, at Seal Beach. The directors are T. J. Conaty, of Seal Beach, John F. Hood of Los Angeles, and J. F. Sheran of Alhambra.

Dr. C. Van Zwalenburg of Riverside fell down a flight of stairs at the River-

side Hospital May second and fractured his right femur. It is unfortunate that he is forced to take that sort of a vacation, and we sincerely hope he will make a thoroughly satisfactory recovery.

The 27th annual meeting of the Orange County Medical Association was held May second. The following are the new officers: Dr. R. A. Cushman of Santa Ana, president; Dr. G. H. Shank of Huntington Beach, vice-president; Dr. W. C. DuBois of Santa Ana, secretary; Dr. H. S. Gordon of Santa Ana, treasurer, and Dr. C. D. Ball of Santa Ana, librarian.

Suggestion to our Supervisors of Los Angeles County: Considerable revenue could be derived by issuing right of way badges to physicians, as is done in Chicago. The badge and accompanying certificate entitle the holder to the right of way when proceeding to the scene of an accident or answering professional calls. A fee is charged for registering those to whom such badges are given.

The Arizona Medical Association held its annual meeting in Phoenix and chose Douglas as the next meeting place. The following officers were elected: President, Robert Ferguson of Bisbee; first vice-president, Dr. W. W. Watkins of Phoenix second vice-president, Dr. J. C. Carlson of Jerome; third vice-president, Dr. F. T. Wright of Douglas; secretary, Dr. C. E. Young of Prescott; treasurer, Dr. R. D. Kennedy of Globe. Delegate to the American Medical Association, Dr. John McLoone of Phoenix.

Every "quack" doctor in the state will be put out of business inside of a year, and all obnoxious advertising will be past long before that time, according to the report of the state board of medical examiners, now in the hands of Gov. Johnson. In the past year 272 applicants representing every sect occult practicing drugless healing in the state were given examinations. Sixty-five were denied certificates, 71 were deferred and 76 finally qualified. There were 42 convictions under the state medical practice act.

BOOK REVIEWS

DUCTLESS GLANDULAR DISEASES. By Wilhelm Falta, Vienna. Translated and edited by Milton K. Meyers, M.D., Neurologist to the Lebanon Hospital and to the Dispensaries of the Jewish and St. Agnes Hospitals, Philadelphia. With a foreword by Archibald E. Garrod, M.D. (Oxon.), F.R.C.P. (London), F.R.S., Physician to St. Bartholomew's Hospital, London. Second edition. With 101 illustrations in the text. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street. Price \$7.00 net.

This volume deals quite satisfactorily with the clinical aspects of the diseases of the ductless glands. Experimental physiology and pathology are presented in German best by A. Biedl. In this new edition of Falta, there has been a revision of the text, and some abstracts of recent literature have been added to the addenda. The American edition is rather preferable to the original German, in that here we find the subject more complete through the addition of recent American and English views. These are placed in addenda at the end of nearly every chapter. Falta admirably separates the various groups of ductless glandular diseases by well-defined lines. This delimitation of the various groups of ductless glandular diseases is a most desirable generalization, enabling us to appreciate not only the various parts which the different ductless glands play in the make-up of an individual disease picture, but also to individualize in our diagnosis. It is important to ascertain what symptoms the individual ductless glandular diseases have in common, and then pleasure and refinement in diagnosis may be found in the recognition of differences between individuals of the same group. This volume should be heartily welcomed, inasmuch as it is a systematic attempt to shed scientific illumination that may in great measure dispel the stygian darkness that has so long enveloped the ductless glandular diseases.

SURGERY IN WAR. By Alfred J. Hull, F.R.C.S., Major, Royal Army Medical Corps; Surgeon, British Expeditionary Force, France; Late Lecturer on Sur-

gical Pathology, Royal Army Medical College, Millbank; and Surgeon, Queen Alexandra Military Hospital. With a Preface by Sir Alfred Keogh, K.C.B., M.D., Hon. Physician to H. M. The King, Director-General Army Medical Service. With 26 Plates and 55 Text Figures. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street. 1916.

This handy little volume, written by English physicians who are familiar with their subjects, is admirably adapted for the use of physicians who desire to brush up on modern war surgery, especially those who may be inclined to take advantage of the training afforded in our summer camps during the next few months. In fact, medical men could do no better duty to themselves and their country in the way of "preparedness" than by perfecting their knowledge concerning modern war surgery. It is a pleasure to recommend this work.

PROGRESSIVE MEDICINE. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D. Professor of Therapeutics, Materia Medica, and Diagnosis in the Jefferson Medical College, Philadelphia; Physician to the Jefferson Medical College Hospital; One Time Clinical Professor of Diseases of Children in the University of Pennsylvania; Member of the Association of American Physicians. Assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia; Ophthalmologist to the Frederick Douglass Memorial Hospital and to the Burd School; Instructor in Ophthalmology, Philadelphia Polyclinic Hospital and College for Graduates in Medicine. VOLUME I, March, 1916. Surgery of the Head and Neck; Surgery of the Thorax, Excluding Diseases of the Breast; Infectious Diseases, Including Acute Rheumatism, Croupous Pneumonia, and Influenza; Diseases of Children; Rhinology and Laryngology; Otology. Lea & Febiger, Philadelphia and New York. 1916.

We cannot more than mention a few of the many important matters considered in this excellent digest. One of the most important recent announcements is that of Plotz, Olitzky and Baehr concerning the discovery of the bacillus of typhus fever and the beginning of important researches upon serological studies in connection with it.

Possibly next to this comes the announcement of Noguchi of his success in growing vaccine virus and so producing a perfectly sterile material for use in human beings. This will aid materially in the laboratory diagnosis of smallpox. Petruschky has conducted some remarkable experiments in immunizing human beings from tuberculosis and also in treating certain cases of the disease by means of the percutaneous method. His suggestions would seem applicable to some other diseases of bacterial origin. There have been numerous important articles on typhoid fever, emetin, pellagra, the Schick reaction and many other topics of interest.

THE PRACTICAL MEDICINE SERIES, Comprising Ten Volumes on the Year's Progress in Medicine and Surgery. Under the General Editorial Charge of Charles L. Mix, A.M., M.D., Professor of Physical Diagnosis in the Northwestern University Medical School. **VOLUME 1, GENERAL MEDICINE.** Edited by Frank Billings, M.S., M.D., Head of the Medical Department and Dean of the Faculty of Rush Medical College, Chicago. Price of this volume \$1.50. Price of the Series of ten volumes, \$10.00. Chicago. The Year Book Publishers, 327 S. LaSalle Street.

It is interesting to note that a special section of eighteen pages is devoted to the recent literature on the diseases of the ductless glands.

REFRACTION OF THE HUMAN EYE AND METHODS OF ESTIMATING THE REFRACTION. Including a Section on the Fitting of Spectacles and Eye-glasses. By James Thorington, A.M., M.D., Emeritus Professor of Diseases of the Eye in the Philadelphia Polyclinic and College for Graduates in Medicine; Member of the American Ophthalmological Society; Fellow of the College of Physicians of Philadelphia. Three Hundred and Forty-four Illustrations, Twenty-seven of which are colored. Price \$2.50 net. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street.

This is an amalgamation of the author's works "Refraction and How to Refract", "Prisms" and "Retinoscopy". The contents of these books have been rearranged in this volume and coordinated by amplifications, modifications or deletions, so as to produce a work suitable for be-

ginners in Ophthalmology and particularly for those who have a limited knowledge of mathematics and who cannot readily appreciate the classic treatise of Donders. All of James Thorington's works are standard.

BACTERIOLOGY AND PROTOZOOLOGY. For the Use of Nurses. By Herbert Fox, M.D., Director of the William Pepper Laboratory of Clinical Medicine in the University of Pennsylvania. Second Edition, Revised and Enlarged. 12mo, 251 pages, with 68 engravings and 5 colored plates. Cloth, \$1.75, net. Lea & Febiger, Philadelphia and New York, 1916.

This work was designed as an elementary text-book of Bacteriology and Protozoology for nurses and for beginners, but it is also a useful book to the general practitioner. Without being technical, it gives a good idea of the nature of microorganisms, and then discusses with more emphasis the ways in which bacteria pass from one individual to another, how they enter the body and act when once within, and their manner of exit. Such general information concerning the character of the disease process has been included as would clarify the nature of microbe action.

In the second edition much has been added concerning general disinfection, the transmission of infection, especially in regard to those diseases spread by insects, and the peculiar phenomena of hypersusceptibility, a subject which becomes wider in its significance as we learn more about it. Throughout the book such material has been included as was necessary to bring it up to date. This is an excellent elementary text-book on bacteriology and protozoology.

THE CLINICS OF JOHN B. MURPHY, M.D., at Mercy Hospital, Chicago, December, 1915. Published Bi-Monthly by W. B. Saunders Company, Philadelphia and London.

When reading the Clinics, it requires little exercise of the imagination to picture Dr. Murphy conducting a clinic and talking to his class.

MISCELLANEOUS

LOS ANGELES CITY CHARTER.

How Would You Like to Have a Plumber or a Policeman as Chief of Your Health Department?

Despicable, Deplorable and Devilish Charter Provisions.

By Dr. L. M. Powers, Los Angeles, Health Commissioner.

While the old charter could be bettered I cannot see any improvement in the new charter so far as the Health Department is concerned.

The provisions of the new charter place the Health Department in a group of departments that are not altogether relative under the control of a commission of Public Welfare, which on the face of things is very unlikely to have any expert knowledge or particular interest in the protection of public health, and at the same time it takes from the Health Department matter that directly relates to preventive medicine. Restricting the Health Division to the care of contagious and infectious diseases and inspection of foodstuffs, only, limits the power or control of the prevention of disease in many directions, and confines only the most difficult, and what many people consider objectionable work, to this division, because there is very little constructive work allowed in this division.

There are assigned to this commission, as provided in the proposed charter, seven different divisions of work, of which three have nothing to do with health conditions, and one has only a slight bearing. The matters of employment agency, the work of the Public Defender, the activities of a society for humane treatment of animals, while desirable, are certainly foreign to public health work, and have been, and may be in the future, antagonistic.

It will be a peculiar state of affairs, when the Health Officer is endeavoring to control rabies, to have his scientific knowledge and expert opinion as to the

necessities in the case, opposed in the same department of Public Welfare by the sentimentalities of those who prefer dogs to babies.

While charities and corrections have nothing to do with sanitation or the prevention of disease per se, the caring for the indigent sick outside the Health Department, where this division should naturally fall, would necessitate an extra staff of physicians outside of the Health Department.

A division for research and social betterment is provided, providing for the study into the causes of poverty, delinquency, crime, and disease. The study of the causes of poverty, delinquency, and crime requires expert sociologists, but should not come under the division of public health. The study of the causes of disease is a public health matter exclusively.

The work of the control of housing conditions, which, to a very great degree is based on public health consideration, is removed entirely from the control of the officer who is charged with the protection of the public health. This is a peculiarity which cannot be satisfactorily explained.

There is a positive certainty of having to work under the control and direction of a commission not technically prepared to direct the work, and possibly antagonistic to proven and advanced ideas of preventive medicine; for making up a commission which has so many varied interests to supervise will give but slight chance for trained sanitarians to be appointed on this commission.

It is to be expected that the individuals chosen for these positions will be such as are interested in some particular branch of the work. The work is so diverse that it will require that no two of the commissioners shall have knowledge and experience on any one subject. Under such a condition it is clear that the work of public health will be under

the direct control and supervision of a commission of whom four-fifths, at least, have no expert knowledge in this direction.

Such a commission, certainly, could not expeditiously dispose of the problems of public health. Friction would probably arise, which would either result in having no measures passed, or result in compromises of such vital importance as to reduce the value of such measures to almost nothing.

Finally, there are **no requirements or qualifications for the director of the Health Division**. It does not seem proper that political influence and untrained ideas should be allowed to determine what sort of qualifications the director should have, but that at least, the choice should be limited to such as, under the laws of the state, are recognized as having had certain and sufficient training to fit them for assuming the responsibilities of life and death over the citizens of the state.

OIL FIELD NORTH OF COALINGA, CAL.

The oil prospects and resources of the area extending northward from the Coalinga district to the vicinity of San Francisco Bay, Cal., form the subject of a report issued by the United States Geological Survey resulting from investigations made by geologists Robert Anderson and R. W. Paek.

This area lies along the west side of the San Joaquin Valley, between latitudes $36^{\circ} 15'$ and $37^{\circ} 45' N.$, occupying a position similar to that of the Coalinga and Midway oil fields near the south end of the same valley. As it contains many geologic features like those found in the productive fields, it has been regarded as a likely place to prospect, and in order to find out whether or not commercial pools of oil probably occur here the Geological Survey made an examination of the area.

It is not believed probable that any large oil field will be developed in this

region, but several small areas offer promise of yielding oil in commercial quantities. These areas lie about The Vallecitos; near Ciervo Mountain, a point in the foothills about 25 miles north of Coalinga; and near Tesla. Besides describing the areas in which little or no drilling has been done the report discusses briefly the Coalinga field, attention being given particularly to the deep sand that has been found in a few wells in the East Side field. The areas in which prospecting for this sand may be carried on with reasonable assurance of success are fully described.

Besides describing features that are of immediate value to the prospector in this region, the report discusses the origin of the oil and the geologic features that control its accumulation throughout the San Joaquin Valley. The oil is apparently formed from tiny animals and plants that were buried in the silt and sand on the floor of the ocean. These sediments were later hardened into the shales and sandstones that are found in the oil fields. The oil is concentrated in certain places, chiefly where the rocks are bent or folded upward to form anticlines. Thus two conditions seem to determine the points at which oil accumulated along the borders of San Joaquin Valley, first, the presence of a considerable quantity of shale of organic origin, and second, the existence of anticlines and synclines running out toward the valley and producing pockets that collect and hold the oil.

To persons interested in the stratigraphy and structure of the Coast ranges of California the report will be of interest, for it describes and maps an area where the peculiar structure typical of that province is well shown, and it contains a wealth of detail regarding the Tertiary and Cretaceous stratigraphy.

This report, Bulletin 603, Geology and oil resources of the west border of the San Joaquin Valley north of Coalinga

Cal., may be had on application to the Director of the U. S. Geological Survey, Washington, D. C.

MINING DISTRICTS OF NEVADA.

United States Geological Survey Report on Humboldt County.

The results of reconnaissance work in Nevada by F. L. Ransome have been published by the United States Geological Survey as Bulletin 414, "Notes on some mining districts in Humboldt County, Nev." The bulletin embodies the results of a reconnaissance examination of some 7,000 square miles, including the Seven Troughs, Rosebud, Star, Unionville, Humboldt, Fitting, Chafey, Kennedy, Adelaide, Red Butte, and Coppereid districts. Some of the districts examined, such as Seven Troughs, Rosebud, and Red Butte, have been prospected only within the last decade; others, like Star City and Unionville, reached their acme of productiveness in the sixties and have not yet participated in the recent general revival of mining activity in Nevada; one or two, like Chafey, have received new names and have been exploited in various ways that modern experience and ingenuity have devised for this purpose; still others, like Adelaide, have been intermittently active for over 35 years, oscillating between prosperity and decay. Mr. Ransome discusses the mineralogy, geology, and mining operations of the region. His conclusion is that the southern portion of Humboldt county is part of a metallogenetic province characterized chiefly by the prevalence of antimonial ores of silver with numerous and widely scattered deposits of stibnite and cinnabar. There are in addition some deposits of gold-silver, copper, and nickel-cobalt ores. Ore deposition probably began immediately after the intrusion of the Triassic and Jurassic sediments in late Mesozoic time by a granitic igneous rock of the same kind as that which

invaded the sedimentary rocks of the Sierra Nevada at the same period and continued into the Tertiary. The known Tertiary deposits are essentially gold-silver ores and copper ores, but it is possible that some of the other types are also Tertiary.

LARGER MAGNESITE PRODUCTION.

The crude magnesite produced and sold or treated in the United States in 1914 amounted to 11,293 short tons, valued at \$124,223, which is 17.2 per cent. greater than the production of this material in 1913, when 9632 tons were produced, valued at \$77,056, according to Charles G. Yale and Hoyt S. Gale, of the United States Geological Survey.

Magnesite is used for making soda-water gas, refractory bricks, furnace hearths, crucibles, and other articles, for digesting and whitening wood-pulp paper, in cement making, and for various other purposes. The production is still derived from California exclusively, the material having been obtained principally from one of six mines in the counties of Alameda, Santa Clara, Sonoma, and Tulare.

The value assigned to the domestic production is computed at the rate of \$25 to \$30 a ton of ordinary calcined (not ground) magnesite in sacks at San Francisco, a rate about equivalent to \$10 to \$12 a ton for the raw magnesite at the same point. The figure of \$11 a ton for the crude product at San Francisco has therefore been taken, which is \$3 a ton higher than in 1913.

The consumption of magnesite in the United States in 1914 was about 122,000 tons calcined and 13,000 tons crude imported and 11,293 tons of raw magnesite, equivalent to about 5000 tons calcined, for the domestic production, a total equivalent to about 132,000 short tons figured as calcined magnesite. As a whole, therefore, about 96 per cent. of the magnesite used in the



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United States is imported, of which nearly 93 per cent. comes from Austria and Hungary and is used for making refractory materials, most of the remaining 3 per cent. being imported from Greece.

The discovery of several new deposits of magnesite near Towle, in Placer County, Cal., was reported to the Survey early in the year, but investigation shows that these are probably not of large value. Reports of several other deposits hitherto unrecorded were also received, including magnesite and dolomite near Bagdad, San Bernardino County, and magnesite near Victorville, also in San Bernardino County. A report on a deposit near Benson, Ariz., was also received, with samples.

K-Y ANALGESIC.

Most doctors realize that as a symptom, pain has as a rule considerable diagnostic significance. Sometimes, at least, if not often, the doctor is apt to overlook one fact, viz., pain to the patient is a **condition**, not a symptom—he cares less for what it means, than to get relief from it.

Hence the doctor is sometimes caught upon one horn of a double dilemma. To relieve pain by ordinary means—i. e., hypodermatic injection or narcotic, given per os, is to satisfy the patient but mask or alter the meaning of certain symptoms.

If the patient is left to suffer while the case is studied, the diagnosis is favored, but patient and friends resent what seems to them to be neglect. The use of opium or similar drugs to relieve pain is always fraught with danger—it's almost as bad as trying to cut off a dog's tail behind his ears. Nature has provided a means for pain relief or analgesia that deserves more careful and general use. In the arrangement of the sympathetic nervous system, the spinal distributing and reflecting centers, lies the explanation of the good

effect of counter-irritation and analgesic produced through the skin by local and external application.

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THE DIAGNOSIS OF THE INTERNAL SECRETORY DISORDERS.

BY HENRY R. HARROWER, M.D., F.R.S.M. (LOND.), LOS ANGELES, CAL.

II.

The Detection of the Minor Thyroid Dyscrasias.

A full appreciation of the clinical importance of the disorders of the thyroid gland presupposes a knowledge of the essential role that it plays in the regulation of the functions of the body. Truly it is a most wonderful organ, and it has been called very aptly "the keystone of the endocrinous arch." As such it is the most important single factor in the direction of the intricate workings of metabolism, for it has been well affirmed that the thyroid governs growth and development—physical and mental, controls the breaking down of certain food materials, particularly albumen, and regulates the complex chemical processes by means of which the cellular wastes are disposed of. As a consequence of this, many different physiological manifestations are intimately bound up with the work of the thyroid; and its functional disorders, no matter how slight, are immediately reflected in such functions as heat regulation, muscular efficiency, peristalsis, urinary excretion especially the elimination of nitrogen, menstruation and other

activities of the gonads both in the male as well as the female, the different features of mental capacity, hematopoiesis, nutrition especially of the skin and its appendages, as well as the development of features, form and function generally.

The thyroid hormone also has much to do with the powers of the body to resist disease. Sjaous was among the earliest to connect its work with the production of immunity, and it has been shown to be the most important of the numerous detoxicating agencies at work in the body. This last makes the thyroid especially susceptible to the toxemias associated with the infectious diseases and the infections, in fact the chief causes of thyroid insufficiency—the minor and by far the most frequent form especially—are the infectious diseases, principally tuberculosis, syphilis and the exanthemata and, of course, typhoid, diphtheria, rheumatic fever, influenza, erysipelas and many other acute or chronic infections.

The predominating influence of the

thyroid upon the functions of the gonads renders it peculiarly sensitive to variations in the sexual life, especially in women; and emotional or sexual excess, as well as the toxic and functional disorders associated with pregnancy are frequent causes of the slighter forms of thyroid insufficiency.

The intimate relation of the thyroid to metabolism, particularly that of proteids, makes it react to that unfortunately all too common etiologic factor in so many disorders—overfeeding, and this is particularly true of a diet in which meat forms a generous part. Intoxications of all kinds—intestinal, alcoholic, drug and those due to amebae in the mouth or tonsils and to intestinal and other parasites—are not infrequent exciting causes of a breakdown in the thyroid function.

With the foregoing suggestions in mind, coupled with the fundamental physiological fact that the thyroid is as important a factor as any in the detoxicating and immunizing process of the body, it will be clear that the detection of a minor functional disorder of this gland may be of much more service than merely to direct attention to the measures necessary to reinforce the work of the lagging gland. A much more important thing will have been accomplished if, in addition to this, the underlying causative element is laid bare and steps taken to eradicate it or to nullify its influence. Very, very often the proper adjuvant treatment of thyroid inadequacy,—the treatment of its cause as well as its results—is made possible by applying our increased knowledge in the right way. Hence we would naturally supplement thyroid medication with emetine where alveolar or tonsillar amebiasis is present whether the infection has made itself prominent or not. Bacterial vaccines would be administered where there is a definite underlying bacterial origin, autogenous vaccines where cultures may be made easily, or, better still, mixed stock vaccines, especially where it is difficult to locate the nidus of infection

and secure a culture. Again systemic alkalinization is very much in order where acidosis and toxemia are prominent; in fact in almost every case of chronic benign thyroid insufficiency, generous and judiciously timed doses of sodium bicarbonate will make the response to thyroid therapy much more satisfactory. Where intestinal concretions are palpable and stasis is obvious, eliminant and lubricating remedies facilitate the best results by removing the wastes which not merely aggravate the manifestations of thyroid disorder, but hinder every function of the body.

For these reasons, then, I rarely employ thyroid medication without some associated treatment, and am confident that many a failure in this line of therapeutic effort is due to the omission of the necessary adjunct measures; for many a time it will be found that a certain method of treatment is rendered much more efficient by the addition of thyroid (say, $\frac{1}{4}$ or $\frac{1}{2}$ a grain three times a day), while the reverse is equally true—thyroid therapy is enhanced by combining with it other suitable treatment the need for which is too often overlooked.

Before we pass from the consideration of the underlying basis of thyroid disorder, a word of emphasis may be advantageously placed right here. Has it ever occurred to the reader that one of the commonest features of the heavy eater or drinker is obesity, and that this is also a common and quite constant feature of hypothyroidism? Why should the thyroid glands of those who are wont to abuse their bodies be so immune to the influence of the very factors which most commonly disturb their function? They are not, and an almost constant feature of such individuals is hypothyroidism manifested in not a few disorders other than the one just mentioned, of which we shall shortly learn.

All these exciting factors, and others quite similar to them, are clearly much more effectual disturbers of the chemical routine of the thyroid gland when the individual has an unstable thyroid

mechanism to start with; and as with the major thyroid diseases, about which we shall have more to say later, **heredity** is the one great foundation upon which a susceptibility to thyroid dyscrasia is built. This is the great predisposing cause, while the toxemias and other circumstances previously mentioned are the exciting causes.

Many conditions combine to favor the production of congenitally subthyroidic children, most important among which are various degrees of the same disorder in the parents and especially the mother. Transmitted tendencies toward tuberculosis, malnutrition and other congenital ills to which the flesh is all too often heir, not forgetting inherited syphilis—a most potent cause of every kind of functional and organic disease of the glands of internal secretion—are almost invariably associated with thyroid instability, and by this is meant, not necessarily definite thyroid disease of varying degree, but an inherent weakness of the gland which permits it to succumb to the first serious stress that may be put upon it.

Usually this extra strain may be the result of some of the common infectious diseases of childhood (incidentally children with this unstable condition are just the ones who “catch everything”) or it may not appear until puberty, at which period many a thyroid insufficiency of more or less permanency first makes itself manifest.

Other factors which favor the hereditary subthyroidism in children are toxemias during pregnancy and labor prior to their birth. I have frequently found a connecting thread between such conditions and the complex endocrinous disorders which I am so often called to see, and it would be interesting to see a report of the thyroid findings in a goodly number of individuals whose advent into the world was the occasion of eclampsia, some figures which I do not believe have yet crept into medical literature. Important among the other predisposing hereditary causes of thyroid instability are

unduly frequent childbearing, prolonged lactation and other physical strains upon the system of the mother during pregnancy. Acute infectious diseases of the mother may cause this unfortunate tendency in her offspring; though it should be said with emphasis that these conditions just mentioned do not necessarily spell thyroid inadequacy in the child and, of course, a constitution may be acquired after birth and in spite of a poor heredity.

Perhaps additional emphasis should be given to the importance of syphilis as a predisposing as well as an exciting factor in this class of cases. We are taught to consider syphilis as a prospective cause of every obscure and difficult condition, and to presume its presence until it is definitely ruled out. This is the correct way to look at the subject though it is not the usual way. The advent of the Wassermann test and its standardization and control by other procedures, has made it possible to know with definiteness whether the syphilitic factor is present or not, and every insidious case of this character should have the benefit of the Wassermann test at least of the blood, and not infrequently of the spinal fluid also.

Syphilis is the most insidious of all diseases and is most protean in its manifestations and Dr. Lewellys F. Barker, of Johns Hopkins University, was right when he recently told the New York Academy of Medicine that “the more my experience grows, the more I am inclined to take as a diagnostic aphorism, ‘When in doubt have a Wassermann test made; when not in doubt still have a Wassermann test made.’” And in no class of disorders is this more truly applicable than the obscure and insidious, just like the obvious and organic, diseases of the glands of internal secretion.

Having attempted to direct attention to the numerous contributory causes of thyroid dyscrasias, as well as to the factors which are likely to precipitate slight or well marked thyroid insufficiency, we can now more intelligently proceed to consider the clinical results of this condi-

tion and to the study of how to detect the usual and unusual symptoms of this common disorder.

EDITOR'S NOTE: Thyroid dyscrasias are by far the most common of all the endocrinous disorders and the clinical findings more numerous and complicated,

hence the consideration of this subject constitutes the largest unit in this series. It has been thought advisable to divide this article and the remaining half will appear in our issue for July.

Next month a continuation of the article on "The Detection of the Minor Thyroid Dyscrasias." Even more interesting than the above!

CASES ILLUSTRATING TYPES OF ARTERIO-SCLEROSIS AND ATHEROMA.*

BY DR. WM. WATT KERR, PROFESSOR OF CLINICAL MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO.

There is much difference of opinion in the minds of pathologists regarding the advisability of making any clinical distinction between these two conditions. The dualist maintains that in arterio-sclerosis there is a more or less uniform thickening of the entire circumference of the blood-vessel, a thickening or strengthening of all the coats so that the lumen is narrowed, that the disease is best marked in the smaller arteries, and that there is little tendency towards degeneration. That in atheroma, on the other hand, the vessel wall is affected in points or patches which may coalesce so as to include a considerable area, that at first the deposits in the affected areas are soft and gelatinous, but may undergo hardening and calcareous transformation or break down into molecular debris, that the aorta is most frequently involved, then the coronary and cerebral vessels. Osler, Tyson and others, who are regarded as unicists, speak of arterio-sclerosis and atheroma as synonymous but divide them into diffuse and nodular varieties.

The views of pathologists relative to the vascular coat first involved are equally conflicting. Coplin gives it as his experience that in both processes the initial change is a fragmentation of the elastica, while others regard this as a later change. With the fragmentation of the elastic lamina there is also a formation of new connective tissue between the elastic lamina and the endothelial lining so that there is a gradual encroach-

ment upon the lumen of the vessel; and Saville has strongly urged that there is a demonstrable increase in the muscular coat of the affected vessel. (Coplin, "Manual of Pathology," 531). In the more advanced stages the disease extends to the media and adventitia and is associated with degenerative changes.

Therefore with the indefinite information now at his disposal the clinician must remember that there are two varieties of this morbid process, each of which tends to interfere with the flow of blood through the parts of the body affected, and that where the lesions are focal there is a greater tendency to perforation of the vessel wall leading to aneurism and apoplexies.

It is impossible for anyone to give a full account of the symptoms and physical signs that may arise in cases of arterio-sclerosis for that would necessarily include a description of all abnormal phenomena consequent upon the disturbed function of the organ or organs whose nutrition was impaired. In arterio-sclerosis of the cerebral vessels we may have any mental symptom from brain fag to cerebral softening; if the renal arteries are involved, anything from the malaise consequent upon defective elimination to the evidences of a fully developed nephritis; if those of the limbs be involved, we may encounter any evidences of impaired nutrition from tingling to gangrene of the toes, and so on throughout all the organs and tissues of the body. It would therefore seem that if we are

*Read before the San Joaquin County Medical Society, Stockton, May 26th, 1916.

to arrive at a diagnosis we must in each case look for signs that would warrant the assumption that arterio-sclerosis exists; then if we are satisfied positively upon this point, consider whether the symptoms of the patient can be explained by arterio-sclerosis of the tissue from which the symptoms are supposed to arise; and lastly we must eliminate all other causes capable of producing similar symptoms.

It might be thought that the condition of peripheral vessels such as the radial artery, was an unerring guide to that of vessels in other parts of the body, but this is not so. A comparatively healthy condition of the radial and temporal arteries does not warrant the conclusion that the deeper seated vessels are also exempt, because observation has shown that the aorta and coronaries are most susceptible to sclerosis, and next to them the mesenteric arteries. On the other hand, an undue thickening of the radial artery indicates the probability of analogous changes in the mesenteric arteries and in the aorta. ("Arterio-Sclerosis," Warfield, 1908, pp. 30 and 49.)

For this reason we must extend our observation and look for such indications as increased blood pressure, left cardiac hypertrophy, accentuated second sound at the aorta, and retinal haemorrhages. In the absence of demonstrable changes in the superficial vessels there is generally a sufficient number of these other indications present to establish a diagnosis in patients suffering from arterio-sclerosis.

The study of a disease with such a variety and distribution of symptoms can be made most profitably by analyzing a few cases illustrating it.

Case I. points directly to the circulatory system.

Mr. L—, 54 years of age, merchant, several weeks ago went to a tree in his garden and reached up to pick some fruit. Since that time he has had pain in the chest upon walking and upon undertaking any exertion; it is more readily induced after food, and radiates to the left arm, especially in the neighborhood of the deltoid muscle, and also

to the jaw. The kidneys and bowels were normal but he had been gouty for many years, and was subject to attacks of hoarseness without any apparent cause. Examination showed the heart apex to be five inches to the left of the mid-sternal line, the aorta two and three-quarter inches to the right of the mid-sternal line in the first interspace, and two inches to the right in the second interspace. There was a slight systolic murmur at the mitral area, with a double murmur in the aortic area. Systolic pressure was 180, diastolic 110. The arteries were thickened generally and the case evidently one of arterio-sclerosis with dilatation of the aorta. There was no luetic history. The evidences of gout from the presence of tophi were very distinct, but the patient could not tolerate either colchicum or iodide of potassium, two grains of the latter causing iodism. Sajoden tablets, however, were easily borne—one tablet three times daily—and in addition to this he took six drops of spirits of glonoin three times daily.

He persisted in the treatment faithfully so that at the end of three months he was able to walk ten blocks at a moderate speed without experiencing any trouble. The area of cardiac dullness at this time only extended four inches from the mid-sternal line, while the aortic dullness on the right side was diminished by one and a quarter inches. Shortly after this he had an acute attack of gout which disappeared in a few days, after he had taken one or two doses of calomel. The patient persisted in the sajoden and glonoin treatment, so that at the end of eight months he could walk more than a mile without the least discomfort and in fact had not suffered any pain for nearly three months.

The systolic pressure was dropped to 153, the diastolic remaining 110. It would be tedious for me to give the progress of the case in detail—it is sufficient to say that he continued the same treatment and at the end of twelve months could walk any distance without discom-

fort unless he was hurried or excited. His statement is that he walks as quickly as the average man. This is a fairly typical case of the more common form of arterio-sclerosis. You will notice that under the treatment the systolic pressure dropped from 180 to 153, a difference of twenty-seven m. m., whilst the diastolic remained the same. This, however, meant a great diminution in the heart load, and consequently would account for the disappearance of the anginal symptoms, because as the patient's normal heart load is supposed to be about fifty per cent of his diastolic pressure, therefore in this case before treatment the load was 70-110 or nearly 64 per cent of his diastolic pressure, whereas after treatment it was 43-110 or only 39 per cent of the diastolic pressure. It is especially instructive by showing the improvement that may take place when the patient can be induced to continue the same treatment for a long period of time.

The symptoms of arterio-sclerosis do not always point so distinctly to disease of the circulatory system as in the previous instance.

Mr. R., aged 56, until the last few years always used wine freely, and even now eats very heartily. Probably there was a luetic infection when a boy. For nearly a year he has noticed that he tires very easily, and that by the afternoon his legs feel very big and heavy, so that he can hardly lift them, yet there is no paresis either sensory or motor, the patellar reflexes are present and equal, neither is there any Rhomberg or other symptom either of locomotor ataxia or paralysis of any kind; all the peripheral blood vessels are thickened, and there are faint systolic murmurs in the mitral area and also over the ascending aorta. He has never noticed any swelling of the lower extremities; the systolic pressure was 180, diastolic 130.

Naturally spinal lues was suspected when the patient made his complaint, but the absence of nerve symptoms, together with the demonstrable evidence of widespread vascular changes, seems to

warrant the conclusion that, although the subsequent development of spinal symptoms may be expected, at present his distress can only be attributed to a general arterio-sclerosis that interferes with muscular nutrition, and specially attacks his lower limbs because he is a man of active habits and his occupation of a rancher compels him to be on his feet during the greater part of the day. Furthermore, the fact that he is all right in the morning and early part of the day, and that the sensation of fullness and weakness only appears after he has been at work for some time, indicates an early exhaustion of nutrition rather than an impaired nerve supply.

In a case such as this one would not be at all surprised at the appearance of intermittent claudication, but so far he has escaped this distressing malady. The medicinal treatment consisted in the administration of a mixture containing bi-chloride of mercury, iodide of potash and arsenic, and in addition to this he used nitroglycerine. Unfortunately the result in this case cannot be given because after three weeks the patient left town and failed to report.

A third patient suffering from arterio-sclerosis in addition to other distinctive signs of disturbed circulatory system, complained that whenever he walked any distance both the upper and lower extremity on the left side became very cold, so that anyone accompanying him would notice the great difference in temperature between the right and left hands, and on several occasions he was seized with such severe pain, most frequently about the middle of the leg on its anterior and outer surface, that he had to stop immediately, and unless he rested for a considerable length of time, was unable to proceed more than a very short distance without inducing a return of the pain. At other times the pain was most severe on the dorsum of the foot, especially in the extensor longus hallucis, and on one occasion I saw him with his great toe so extended that it was almost at right angles to the dorsum of the foot.

As this gentleman might be free from the attacks for many months there can be little doubt that they were due to vascular spasm, arteries in the early stage of sclerosis being particularly prone to this change. Applications of the vibrator were found to be most effective in relieving this condition.

Much of the gastric distress found in old people with weak hearts and thickened vessels is due to sclerosis of vessels in the splanchnic area. The symptoms may be those of extreme gastro-intestinal discomfort with occasional exacerbations, especially at night, or there may be an associated ulceration, or paroxysms of epigastric pain anginal in character.

The following case is a fair example of the last:—Mr. H., aged 71, tourist, had a severe attack of epigastric pain accompanied by a feeling of extreme faintness, and after a time he vomited without obtaining any relief, neither was he benefited by warm applications or draughts of bicarbonate of soda. A physician who had been summoned injected morphine, which made him fairly comfortable for several hours, but after this the pains began to return. Friends who were with him say that they did not notice any blood in the vomitus, nor was there any blood in the feces during the subsequent three days. The patient stated that he had suffered from angina pectoris, and consequently his family physician had cautioned him about diet, but that he had not lived up to instructions while travelling. His urine had been examined regularly, and always found to be normal. There were no cardiac murmurs, but the second sound in the aorta area was accentuated. The presence of general arterio-sclerosis was very evident. On pressure over the aorta in the epigastrium he complained of pain, but there was no tenderness over the gall-bladder. The blood pressure appeared high on digital examination, but owing to the nervous irritability it could not be measured.

A mixture of nitroglycerine and caffeine sodium benzoate was given every

four and then every six hours, so that the pain entirely disappeared, and the patient continued his journey.

At the risk of being tedious there may be mentioned one other symptom occasionally found in patients suffering from arterio-sclerosis, and that is morning headache. This is not the headache of high blood pressure in which there is a throbbing, full feeling in the head, fullness in the ears, and possibly vertigo, but it is a dull ache that appears soon after the patient awakes, sometimes only a few minutes after he has opened his eyes, and generally disappears in from one to two hours. The sounder the patient has slept the more liable is he to have the headache, so that he often explains it by saying that "he slept too hard." It is most frequently found in patients who during the waking hours do not present any symptoms of increased blood pressure, in fact that is generally low, but the phenomenon is not limited to this class by any means, and I have found it in patients whose systolic pressure is persistently high. At present there is one patient fifty-six years of age, whose normal systolic pressure during at least six years has been about one hundred and sixty-five, but for some weeks he had this headache every morning, and then it was found to be as high as two hundred and thirty. Under treatment consisting essentially of rest, restricted diet and increased elimination, the headaches gradually disappeared, and the pressure came down to its usual point.

The explanation is puzzling, but it must be associated with some of the physiological changes that take place during sleep. Experiment has shown that during normal sleep there is always a fall in aortic pressure, it may be as much as fifty millimeters of mercury, accompanied by a diminution in the volume of the brain from lack of blood supply, a dilatation of blood vessels in other parts of the body, and slowing of the pulse.

It is interesting to notice that this combination of diminished pulse rate

with arterial dilatation and fall in pressure is just the opposite of what takes place when one is awake. As the end of the sleep period approaches the pressure begins to rise, but may not reach its usual height until the subject has been awake for nearly two hours. It would appear that the sensibility of all the cardio-vascular centres in the medulla is diminished during sleep and their tonic control relaxed.

Arterio-sclerosis of the cerebral vessels interferes with the nutrition in the brain just as in other organs where blood-vessels are affected, and it is probable that when to this is superadded the great fall in pressure that accompanies sleep the anaemia of the cells in the cortex is excessive. That there is really a temporary impairment of the nutrition of the nerve cells, is suggested by the fact that the awake pressure must have returned for a time sufficient to permit of recuperation before the headache disappears. However, this will hardly explain such cases as that in which the morning headache was only present in the patient of habitually high pressure, when an exceptionally high excursion took place. It may be that the readjustment in the cerebral circulation consequent upon transition from a sleeping to a waking state, may be largely responsible for the discomfort. The blood pressure of the arterio-sclerosis is prone to very much greater variations than that of the normal being, consequently, it is possible that the variation in degree of fullness of the cerebral vessels between sleeping and waking is more in the arterio-sclerotic than in the normal person; and if, in addition to this, there is a change in the arterial walls the circulatory readjustment upon awakening will occur under disadvantages as it must take place through a greater degree and against increased resistance.

The blood pressure in cases of arterio-sclerosis is always a matter of importance. Unfortunately with some men the sphygmomanometer has fallen into disrepute, most probably because they are

weary of hearing high blood pressure discussed both by the laity and members of our profession as a morbid entity instead of "an outward and visible sign of an inward and spiritual grace." Abnormal variations in blood pressure must be regarded as symptoms, the causes of which are to be explored and treated, but it occasionally happens that the pressure itself may be a source of discomfort, or even danger, that requires special attention, just as in a case of renal colic we may have to use special measures for allaying the pain while simultaneous efforts are being made to secure the passage of the calculus and prevent formation of others.

The object of arterial pressure is to maintain a flow of blood through the **capillaries** of the different organs and tissues so as to insure their efficient physiological activity and nutrition, and it has been shown, especially in regard to the kidney, that this efficiency depends more upon the quantity of blood flowing through the capillaries in a given time than the pressure in those same capillaries. It is a fact that when one organ or tissue is thrown into physiological activity its blood vessels dilate, and an increased flow of blood is determined to it. If this dilatation were to take place over a large area there necessarily would be such a fall in aortic pressure that continuance of this flow would be impossible were there not some means provided for maintaining or even increasing the aortic pressure in response to the demands on the peripheral circulation and we find that this mechanism exists in a reciprocal interaction between the heart, the somatic arterial and the splanchnic arterial distributions.

For example, the ingestion of food is followed by a dilatation of the vessels in the splanchnic area on account of the increased functional activity of the digestive organs, and a similar change takes place in the somatic area because the *paubulum* is being carried away for storage in the tissues. This diminished peripheral resistance would naturally lead

to a great fall in arterial pressure were there not a simultaneous increase in the frequency of the cardiac contractions, causing a greater output of blood so that the pressure does not fall, but generally is increased. It is this compensatory balance that makes the results of experiments with drugs upon the blood pressure so contradictory when compared with those observed clinically, where we so often find evidences both of improved circulation and altered blood pressure. In disease this compensatory apparatus is disturbed on account of the changes in the arterial walls so that it may no longer act efficiently. When therefore, we find the arterial pressure subject to greater than the normal variation, we must conclude that there is some disturbance of this compensatory balance system due either to changes in the blood vessels, or heart, or functional impairment of the vaso-motor centres; and the treatment can only be determined after it has been decided which and how many of those factors are at fault.

It is impossible at present to consider this topic in detail, in fact there can be mentioned only a few suggestions explanatory of some of the apparent discrepancies noticed at the bedside in cases of arterio-sclerosis.

It not infrequently happens that a man appears with tortuous temporal arteries and even an arcus senilis that awakens the expectation of marked signs of arterio-sclerosis, and yet he has few if any, symptoms and there is little change in his pressure. This would lead to the conclusion that his splanchnic area had escaped sufficiently to accommodate the extra blood, or that his heart muscle is so debilitated that it cannot maintain the pressure; but in the latter case there probably will be dyspnoea too easily produced by exertion and other signs of incipient cardiac failure. It may be that the patient shows not only thickened and tortuous arteries, but that the blood pressure is abnormally high, and yet we are surprised that he experiences little

if any inconvenience. We must remember that nutrition depends on the capillary circulation, and while the total number of arteries and arterioles affected are sufficient to raise the blood pressure, because their diminished elasticity demands a greater cardiac motor power to maintain the circulation, nevertheless, the narrowing of their lumina is not so great as to seriously impede the ingress of blood into the capillaries; and under such conditions the rise is entirely compensatory.

Also there are cases with high pressure yet showing indications of impaired circulation where the condition is aggravated by such preparations as digitalis, but immediately improved on a treatment that reduces pressure, and their circulation is actually better on a lower than on a high arterial pressure. Perhaps the most prominent instance of this is the increased flow of urine that often follows the administration of sodium nitrite in cases of cirrhotic nephritis. Here, in all probability, many of the glomeruli are destroyed, but others are supplied by arterioles in an early stage of the arterio-sclerotic process, and we know that these are very prone to spasm; the nitrite relaxes the contraction and permits a more copious flow of blood through the glomeruli with consequent increased urinary secretion, but as there is a simultaneous dilatation of arterioles in other parts of the body, there is a corresponding fall in pressure.

There is only one other clinical incident to which reference will be made, and it is the case of abnormally high pressure in which reduction below a certain point is followed by faintness or syncope, and yet if left to itself may continue to rise and the patient suffer from hyper-tension. In such a case the attempt must be made by frequent and careful use of the sphygmomanometer to find the point at which the patient feels his best, and that is the normal pressure for him. In all probability much of his capillary area is permanently im-

paired, therefore his occupation and habits must be regulated so as to diminish, so far as is compatible with safety and the enjoyment of life, the demands upon the circulation. But if, in reducing the pressure, there is an increase in the tendency to dyspnoea or the production of faintness, then in all probability the coronary arteries are involved, and the aortic pressure has been lowered so that these vessels are no longer sufficiently filled, and the myocardium is starved. It must be remembered that the coronary arteries are not under vaso-motor control like those in other parts of the body, but vary in size with aortic pressure, and consequently a lowering of the latter may be so great as to prevent the increased coronary pressure that is necessary to compensate for the additional resistance induced by the sclerosed narrowing of the vessels supplying the cardiac muscle.

Surely these few remarks are sufficient to emphasize the necessity for making examinations by means of the sphygmomanometer in all cases of arterio-sclerosis, because it is only by such means that each patient's best new, but for him normal, blood pressure can be discovered; and it is only by the presence or absence of changes in each patient's new standard, and the intelligent interpretation of their changes in conjunction with other signs, that any idea regarding the arrest or progress of the disease can be obtained. Furthermore the diastolic must be as carefully estimated as the systolic pressure, this being necessary for the calculation of the heart-load and over-load, since it is only by such means that we can estimate the strain to which the cardiac muscle is subjected. It should never be forgotten that the heart load may be increased either by raising the systolic or lowering the diastolic pressure, a fact of particular importance in connection with the popular notion that mineral baths are always of benefit in cases of heart disease, and the consequent tendency of many patients to

adopt such treatment without medical supervision. A number of patients were observed in my own wards, some suffering from circulatory disturbance and others free from it, their pressure being taken before and after immersion in a warm bath. In all of these the bath was followed by a well marked fall in diastolic pressure, generally to the extent of twenty-five or thirty m. m. In one case of well marked arterio-sclerosis the pressures before the bath were systolic 160 m. m., diastolic 90 m. m.; after the bath, systolic 160, diastolic 70, with a consequent increase in the pulse pressure or heart load of from 70 m. m. to 90 m. m. Extensive observation has shown that the normal heart load for each heart is about fifty per cent of its diastolic pressure; therefore, before the bath this heart already had an overload of 27 per cent, because 70-90 or 77 is the pulse pressure in terms of its percentage of the diastolic pressure, which is 27 per cent in excess of the normal fifty per cent. After the bath it was 90-70 or 126 per cent of his diastolic pressure being an overload on his heart of 76 per cent. As the systolic pressure (160 m.m.) was unchanged by the bath it might have been assumed that the immersion did not influence the heart's work in any way, but the taking of the diastolic pressure revealed the fact that the overload was more than doubled. Such a case explains many of the attacks of angina pectoris and syncope, as well as the sudden death, that occur after patients suffering from heart disease have taken a warm bath. Unfortunately the pressure does not readjust itself immediately upon removal of the patient from the bath, in fact the symptoms often do not appear until the patient has been dried or gone to bed and sufficient time has elapsed for the heart muscle to become exhausted under the prolonged strain of its superimposed overload.

MESENTERIC THROMBOSIS WITH A REPORT OF A CASE.*

BY DONALD W. SKEEL, M.D., LOS ANGELES, CAL.

This condition was first noted by Virchow in 1847 but received little attention until it was brought before the public in an article by Litten in 1875.

Infection is the important etiological factor. This may originate in the appendix or gall bladder. It may follow the severe enterides, surgical infections, milk leg, the puerperium, phlebitis of the lower extremities or sepsis. It may follow an infection in some distant part of the body. In fact all conditions leading to thrombosis of any vessel are to be considered as etiological factors in the occurrence of mesenteric thrombosis.

According to Darnell there is an ascending and a descending type. In the former the main branch of the portal vein is not involved. In the descending type the main branch of the portal vein is involved first and the symptoms of portal stasis predominate. The diagnosis is seldom made and the mortality is 94%. Necropsy shows haemorrhagic infraction and gangrene of the intestine. There is bloody fluid in the peritoneal cavity and sometimes peritonitis. When the infraction is complete the wall of the infected intestine is thickened, oedematous and of a dark red color. The peritoneum covering the affected loop becomes dull. This condition progresses until gangrene occurs. The lumen of the intestine contains tarry black blood. There may be areas of fat necrosis in the mesentery. Intestinal bacteria make their way thru the intestinal wall into the peritoneal cavity (especially the *Bacillus Coli*), and if death does not too soon occur, set up a suppurative peritonitis.

The symptoms are those of a paralytic ileus. At first the pain is very severe, general over the abdomen and somewhat colicky in character, but more pronounced in the epigastrium. When paral-

ysis of the gut has progressed the pain loses its spasmodic character and becomes more constant due to the developing and spreading peritonitis. The tenderness, tho general, is most pronounced about the region of the umbilicus. The vomiting which is at first reflex, consists only of stomach contents. This ceases for a time and then later we may have vomiting of the intestinal contents. Bloody stools of a diarrhoeal character are very characteristic, and occur early. Later there may be obstipation. The abdomen is distended and tympanitic and the rigidity is general over the abdomen. As the peritonitis develops we may find signs of free fluid in the abdomen, sufficient in quantity to cause dullness. The temperature is normal or subnormal. The pallor is extreme and the patient is covered with a cold, clammy sweat. The pulse is rapid, irregular and thready in character. The respirations are thoracic, there being a tendency to prevent movement of the abdominal muscles. Death usually occurs within 18 to 48 hours from the onset of the symptoms.

The diagnosis can to a large extent be based upon the following:—

- (a) Source of the embolism.
- (b) Bloody stools—sudden with no previous intestinal disease.
- (c) Abdominal pain—colicky and severe—later becoming constant.
- (d) Distention of the abdomen with signs of peritonitis and peritoneal irritation.
- (e) Fall in temperature.

The following is a summary of a case reported by Jackson, Porter and Quinby in the *Journal of the A. M. A.*

Case 11 of their series. The patient had had three children, the last, five

*Read before the Los Angeles Obstetrical Society, April 11, 1916.

weeks ago. The previous pregnancy was followed by a "Milk Leg." When seen her temperature was 98.6, pulse 80 and of poor quality. Respirations 23. The abdomen was distended and there were signs of peritoneal shock. Operation showed free fluid in the abdominal cavity and thrombosis of the mesenteric veins. Death occurred in 24 hours from the time the patient was first seen.

CASE REPORT:—

Patient aged 21 years. Height 5 feet 4 inches. Weight 180 pounds. Her mother died soon after patient was born, probably about 2 weeks, but the cause of death is not known. The patient was in good health during her pregnancy, the urine being negative until a few days before her expected date of confinement, October 26th, 1915. On October 18th, 1915, her urine was found to contain a heavy trace of albumin and many hyaline casts. On the 21st she passed 1500 cc. of urine which contained 12 gms. of albumin per litre, and many hyaline and finely granular casts. On the 23rd, 1200 cc. of urine were passed and the amount of albumin had increased. (Exact amount not determined.) There were very many hyaline and granular casts present. She was taken to the hospital and induction of labor started, the cervix being packed with gauze at 5 P.M. Pains commenced at 7:30 P.M. and 3:15 A.M. on October 24th she was delivered of a normal male child weighing 8½ pounds. The child was strong and healthy and showed no evidence of any toxæmia. After delivery the amount of urine passed in 24 hours gradually increased and the casts gradually disappeared. On the 26th the oedema of the legs which had been present since the 18th was markedly decreased and her general condition seemed normal. On the 28th the lochial discharge, which had been normal, suddenly stopped. The patient had a severe chill and her temperature rose to 102. On examination the cervix was found to be tightly contracted and the patient complained of considerable tenderness

over the fundus uteri. A small dilator was gently introduced and the cervix dilated. This was followed immediately by the passage of a large amount of foul smelling lochial discharge. Within an hour her temperature had dropped to 99 and then became normal. The lochia became normal. The patient remained in the hospital for two weeks, refusing to stay any longer because of the expense. After being removed to her home and while still in bed, she developed a phlebitis of both legs at the end of the third week. This was accompanied by some fever but at no time did she have a chill. She continued to have some slight temperature for the next two weeks. At this time her urine was entirely free from albumin and casts.

For about two weeks after the phlebitis appeared the patient had considerable pain in both legs. The swelling and pain gradually subsided and on December 15th, 1915, she was feeling fairly good. That morning I allowed her to be put in a chair by the side of her bed, but cautioned her not to stand or walk. However that afternoon she walked out in the back yard. Very soon afterward she was seized with very severe abdominal pain. She was assisted back to her bed and I was called to see her. When I reached the house about half an hour later, I found her in a state of collapse. Her temperature was sub-normal 96 deg. Her pulse was very weak and thready and almost impossible to count, her respiration 26. She was bathed in a cold sweat, her pallor was extreme and she complained of pain in epigastrium. She seemed to rally after a hypodermic injection of Atropine 1-300 gr., Morphine gr. 1-8, and Digitalin gr. 1-100. Within 15 minutes she again became worse and her abdomen became markedly distended. She had a great deal of vomiting which later seemed to have the appearance of intestinal contents. She had diarrhoea during the evening, some of the stools being bloody. She had continuous pain during the night and was very rest-

less. She gradually grew worse and died on December 16th, 1915, at 1:30 P.M., death having occurred about 22 hours after she was seized with the abdominal pain.

The diagnosis in this case seems to be clear from the symptomatology. It was

impossible to get an autopsy. A consultation was held soon after the onset of the symptoms and it was agreed that operative interference was contraindicated. Hence we have only the history, physical signs and symptoms on which to base our diagnosis.

THE DETERMINATION OF SEX.*

BY E. M. PALLETTE, M.D., LOS ANGELES.

It may be profitable to turn from the study of the more practical and everyday problems of our work to the consideration of one which is as yet purely speculative, but which may some day become of practical value.

All but the lowest forms of both plant and animal life are bisexual. The object of this is to make sure that the offspring shall be the descendent not of one individual but of many. In this way defects which may arise are not necessarily transmitted. The stream, having many sources, may rise higher than any one of them. In this way race-development takes place.

The cause of sex has been a favorite subject of speculation since man began to think. Hundreds of hypotheses have been advanced, the world is full of people who think they know.

The folk-lore of all races abounds with signs bearing upon this subject, and the common, uneducated people of all nations including our own, have many queer beliefs. In Servia a stye upon a man's eyelid means that his Aunt is pregnant. If the stye is upon the upper lid, the baby will be a boy; if upon the lower, a girl.

Hippocrates taught that to produce a male the generative material must be of a stronger quality and must come from the father. The female baby came from weaker material of mother and father. This belief prevailed for many centuries and is held by many of the laity even

to this day. The falsity of this doctrine has long since been proven.

Aristotle taught that the woman supplied the basal material for the development of the future child. Man merely gave the impulse which started development.

It was Anaxogaras who first set forth the doctrine that the origin of the two sexes lay in the two sides of the parents, respectively. The boys come from the right ovary and testicle and the girls from the left. This belief had followers into quite modern times.

Other theories have been based upon climate, temperament, education, nutrition. In 1897, Prof. Schenk, of Vienna, startled the world by proclaiming that sex could be determined at will. He taught that if the metabolism of the mother is so affected during pregnancy that sugar appears in the urine, the child will be a girl; but that if she be kept on a diet that will reduce the carbohydrates and eliminate the sugar from the urine, the offspring will be a boy. Subsequent experience exploded this theory.

During the last century, from the time of Darwin on, there were a large number of investigators who collected statistics widely along various lines bearing upon this subject. One observer's statistics were based upon 59,350,000 births,—one half the population of Europe. Many interesting facts were brought out. The ratio of males born to

*Read before the Los Angeles Obstetrical Society, May 9, 1916.

females was found to be about 106-100. Because of the greater mortality of the male child at time of birth and subsequently, this ratio becomes about equal among adults. Nature compensates for the greater mortality of the male by causing just enough more males to be born to make up for it. Statistics collected in regard to domestic and many other animals which pair off for purposes of reproduction, show the same rules to hold good.

While the many lots of statistics collected and the many writers along these lines differ in minor details, the great majority agree in one fundamental respect. This agreement is so general that we may state the theory as a law of sex-determination. It has been referred to as the cross-heredity of sex (Gekreuzte Geschlechtsvererbung). According to this theory, if the father is stronger, at the time a pregnancy occurs, the child will be a girl: or, if the mother is stronger, it will be a boy. This is what we would expect on purely a *priori* grounds, for in no other way could the equality in the number of the two sexes be maintained. Nature is thus ever striving to fortify the weaker sex.

This doctrine is supported by many facts.

The usual excess of male births has been referred to. This excess has been shown to be increased correspondingly during the time of the loss of many men during times of war, (when not only men are lost, but the stronger men).

Among polygamous people a high birth rate of males has been shown to prevail. While the husband of several wives may be stronger than any one of them, he would not be expected to be stronger than all collectively, from a standpoint of race perpetuation.

Women who have their first born at a comparatively late period of life are much more apt to have boys. The fact that they do have children late in life would indicate that they might have had them earlier, and the fact that they did not

have them earlier would argue for a weakness of the male element, in their immediate environment at least.

The children of unmarried mothers are much more likely to be girls. The explanation offered for this fact is, that only the stronger men are able to overcome the prejudices of the unmarried woman.

When there is an unusual difference in the ages of the parents, the boys come to the family where the father is older, and the girls where the mother is older. Nature here, as elsewhere, is striving to prevent the extinction of the weaker sex.

As obstetricians, we are familiar with the usual "chestiness" of the father of the first-born, if that first-born happens to be a boy. But, in the light of the teaching under consideration, the father of the baby girl has more reason to feel proud, and the Chinese motto "May I be the father of twenty boys" is without justification.

There has been another large school of investigators who have attempted to solve this problem by observation and experiments upon lower animals. They have uniformly found support for the doctrine of cross-heredity of sex. The old stallion begets male colts. The experience of the breeders of cattle and other domestic animals is consistent with this view.

These experimenters upon domestic animals have developed a second law of sex determination. They have demonstrated that sex is determined by the degree of ripeness of the ovum at the time of fertilization; that the ovum, which has not yet reached a certain degree of ripeness produces a female, but that, if this degree of ripeness has been passed, the ovum upon fertilization, produces a male. That is, an early fertilization of the egg-cell produces a female, while a late union of the two germ-cells results in a male. This is found to be true of plants as well as animals. Attention is called to the fact that the later

eggs laid by fowls and singing birds are likely to be males and the last one is always a male. In mammals which bear many young, the last are usually male. This is explained by the hypothesis that the ova passing through the oviduct push the semen back so that the ova which come behind are in a more ripe condition when fertilized.

In frogs the eggs are always fertilized after they are laid. If these eggs are kept for several hours before spermatozoa are mixed with them the proportion of males to females is enormously increased. This is what we would expect from our "first law," for, if left to themselves, an adequate male element would not permit of such a delay of fertilization; and such an enforced, artificial delay has the same effect as an inadequate, weak male element would have, under natural conditions.

There is a third group of researchers who have thrown much new light upon this question. The modern biologist, with his microscope and improved technique, seems to have all but solved it.

Until recent years it was believed that sex was not determined until some time after fertilization. Several American and German biologists however, have definitely worked out, in recent years, that it is determined in the germ-cells at the time of their union, so that it has become immutable by the time the first segmentation of the ovum occurs.

It is a common demonstration in elementary biology classes to place some ova of a starfish under a cover-glass and near these a piece of the testis of the same animal, teased to permit of the free escape of the spermatozoa.

It is interesting to observe the directness and the rapidity with which the spermatozoa propel themselves toward the ova which they swarm thickly about. Many surround each ovum radiating like the proverbial spines upon the Porcupine and each apparently trying to gain admission. Soon the egg throws out a prominence or reception cone opposite

one of the attacking spermatozoa, which immediately buries its head and middle-piece in this. The tail is lost; its function being that of propelling alone.

The ovum conducts herself in a very ladylike manner remaining complacent and at first obdurate to the importunities of her horde of suitors, who likewise behave in a properly vigorous and manly fashion, but at last, she succumbs and receives to her embrace the one of her choice. As soon as the sperm-cell has entered the cone there is a circulation of protoplasm started up within the egg which carries the sperm-cell with its nucleus and centrosome deep into the egg and brings it into contact with the egg nucleus. Of all the sperm-cells surrounding the ovum why does a certain one gain admission to the exclusion of all others? In the answer to this question lies the solution of many of the problems of heredity as well as that of sex determination.

Within the last few years several American Biologists, working independently have demonstrated the existence of two distinct varieties of sperm-cells in man and other organisms, one of which is male producing, the other female producing. This fact has been observed in more than 100 species of animals, belonging to widely different groups. One of these spermatozoa contains a peculiar, "accessory" chromosome; the other does not. The development of these two types of spermatozoa has been carefully worked out by several investigators. It has been long established that the number of chromosomes in the spermatogonia is definite and different for each species. If this is an odd number, as in man, where it is forty-seven the union will have twenty-three pairs and an odd unpaired chromosome. In the subsequent division the pairs divide, the unpaired chromosome going entire into one of the daughter cells, and result in two cells, which give rise to two spermatozoa with twenty-three and twenty-four chromosomes respectively. The former of these,

uniting with an ovum, produces a male; the other a female.

Generally speaking within a species, or a community or between individuals, nature compensates the weaker sex by making the offspring of that sex, and so maintains the numerical ratio unchanged between the sexes. And she does it in this way,—by establishing an affinity between the recently matured ovum and the female producing sperm-cell, and between the more matured ovum and the male producing sperm-cell. The exact method of this has not yet been worked out. But such must be the case, for it is obvious that, generally speaking, early fertilization of the ovum indicates a promptness and consequent strength of the male element, while a late fertilization would argue, in the long run, for a weakness of the male element of the fertilization.

We have then three rules of sex-determination, each arrived at by a separate lot of investigators each approaching the subject from a different standpoint and working along different lines.

The second and third rules are the means by which the first is accomplished. A weaker male element would mean, as a rule, a later fertilization, which, in turn, would mean a fertilization by a male producing sperm-cell. A stronger male element would mean, on the average an earlier fertilization that is a fertilization by a female producing sperm-cell.

The great obstacle to making this practical among human beings is the uncertainty of the time of maturity of the ovum. The physiology of ovulation is not yet well understood. This is all intended in a broad, biological sense only, for the number of actual fertilizations among the human species is so small compared to the possible that individual cases mean very little.

We now all believe in Spencer's Doctrine of "race enhancement." There is but one basis of ethics, of conduct. All things are right which tend to the perpetuation and ultimate survival of the

race; all things are wrong which do not so tend. All variations of function and of structure among organisms have but one meaning—the perpetuation of the species. Perhaps the strongest impulse among living things has to do with reproduction. But there are impulses which tend to combat those of reproduction, for an over production would mean ultimate extinction.

All social aggregates, including the cell-communities which make up the individual organism, have adopted various means of restricting reproduction of the race so as to prevent its exceeding its food supply. We are hearing a great deal of Eugenics, the scientific restriction of reproduction with the aim of elimination of the unsound in mind and body. This is only a new name for what the race has been more or less blindly attempting to do for thousands of years, by such means as monasticism, wars, the adoption of religion, caste and property restriction of marriage, and the prevention of pregnancy and its correction. (We might almost add to this list a modern abomination known as twin beds.)

We should not attempt to meddle too much with the big things of nature, but when we are sure of our ground we can often direct the processes of nature in a way to prevent much waste, with the one aim of race advancement ever in mind, and when the new science of Eugenics comes into its own the intentional and scientific determination of sex may be a part of it.

Seventy-six out of eighty-seven cases of typhoid fever which occurred in a recent outbreak have been traced by the United States Public Health Service to infected milk. Had the first cases been reported to a trained health officer the outbreak could have been stamped out promptly. When will we learn that disease prevention is sure and cheap?

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EDITORIAL

PREPAREDNESS

Physicians and surgeons have always been leaders in preparedness. Today there is probably no class of men so devoted to study, often entailing extended pilgrimages to famed founts of wisdom, that they may learn from the masters of the various arts and sciences and thus be better prepared for the exigencies that may arise in their ministrations. Not infrequently depleted finances to the point of actual privation, determines the degree of preparedness of the disciple of Esculapius, when entering upon his professional career. Devotion to duty, evidenced by a very worthy type of preparedness, prevents very effectually the practitioners of the healing art becoming leaders in finance in any way commensurate with their real ability. With such habits of study and inculcated sense of devotion to duty, the physician is ever ready to meet emergencies in the regular routine of his professional life. When the nation is convulsed by

martial disturbances from without or from within, when the lives and welfare of our brethren are imperiled, the physicians and surgeons always have been and probably always will be found prepared to do their part, prepared to meet such privations as may fall to their lot, prepared to undo so far as possible, the untellable horrors of war. During the present European conflict, the mortality among the physicians and surgeons has been higher than among the fighting forces. But personal danger never has, and probably never will deter medical men from playing the part of the good samaritan, from being true cosmopolites in their attempts to lessen suffering and prolong life.

In the Los Angeles Preparedness Parade, the presence of a large representation of our profession in the Physicians and Surgeons Division, showed that we are in full sympathy with the "preparedness" idea. Aside from the patriotic appeal of Preparedness, in the sense of

being prepared to protect our nation and our homes and loved ones, the Preparedness movement is of still deeper significance to medical men in that it may possibly prevent martial conflict with its attendant suffering and loss of life. Thus "preparedness for Peace" may take its

place as an element in preventive medicine.

When conflict does come, as it will come sooner or later, the physicians and surgeons of Los Angeles will be found prepared to do their part.

EDITORIAL NOTES

Dr. T. C. Coxhead, of Oakland, died May 27th at the age of 94 years.

Dr. J. O. Post and family, of Pasadena, are spending a vacation in Tacoma.

The California Osteopathic Society met in Oakland June 8 to 11.

Dr. A. P. Burroughs has located at Portersville.

Dr. T. O. Lockett has been appointed county physician for Imperial county.

The Children's Hospital of San Francisco has been taken over by the University of California.

The Pajaro Valley Hospital has been opened at 36 West Lake avenue, Watsonville.

Dr. M. Allen Starr, the eminent neurologist and psychologist, has been paying California a visit.

Dr. E. Avery Newton is back from his eastern trip, and looked quite in place in the Preparedness Parade.

Dr. Frances Marshall of Garden Grove, is back from a trip to St. Louis and other eastern cities.

A film drama, entitled Where are My Children, has been advertised as a part of the propoganda for "birth control." Possibly non est.

An Ontario-Upland Society for the Study and Prevention of Tuberculosis has been formed, with Dr. F. F. Abbott secretary.

Dr. C. A. Hanson, of Long Beach, celebrated his seventy-second birthday anniversary recently.

Dr. George H. Kress served commendably as Marshal in the Preparedness Parade. His announcements had the characteristic punch.

Dr. B. M. J. Conlin has returned to Long Beach after a ten days' visit to Ft. Collins, Denver and Trinidad, Colorado.

Ray Nimmo has resigned as attorney for the State Medical Board, and his place has been filled by the appointment of John W. Hart, of Los Angeles.

Dr. George H. Martin, formerly of San Francisco and an ex-president of the State Homeopathic Medical Association, has purchased a residence on Orange Grove avenue, Pasadena.

The California State Nurses' Association, at the San Jose meeting, elected Miss E. Van Eman, R. N., Los Angeles, president and selected San Diego for the 1917 meeting.

Dr. E. M. Bixby, of Pomona, has decided to move to San Francisco, where he practiced a quarter of a century ago. His practice in Pomona has been transferred to Dr. Ralph Smith, who has offices in the Brady building.

Dr. Harold A. Fletcher became a benedict on the twentieth ultimo. The bride was Miss Inez D. Pischel, daughter of Dr. Kaspar Pischel, of San Francisco.

Dr. Fletcher is connected with the Eye, Ear and Nose department of Lane Hospital.

A shipment of salvarsan valued at \$500,000.00 was received in New York, May 25th. Emperor William is reported to have issued a special order directing the shipment.

The supplies for the institutions of the State of California cost over four million dollars last year. The State Purchasing Agent, McMillan is now planning purchasing two million supplies for the fiscal year that begins July first.

Charges that his wife nagged him and pinched him and kept him awake nights are said to be set forth at great length in the divorce suit brought by Dr. Francis M. Pottenger, well known lung specialist and head of a large sanitarium at Monrovia which bears his name, against Mrs. Adelaide B. Pottenger. It is said that the ground on which a legal separation is asked is that of extreme cruelty.

Margaret Sanger, a nurse who has gained some notoriety through her advocacy of "birth control," is quoted as stating that there are four feeble minded children born to every single normal child. It all depends on what you mean by a "normal" child. Strictly speaking the normal individual does not exist. Another quotation: "Women since Eden have been cursed with ignorance—just now the light of intelligence is breaking."

Dr. Stanley P. Black, as health officer of Pasadena bought a supply of potassium permanganate when the drug was cheap, for use in fumigating. War has boosted the price from 13 cents to about two dollars per pound. So now Dr. Black is planning to use a cheaper drug for fumigation, leaving a profit of something like \$3740. Thus the Doctor will save Pasadena probably more than enough to run the entire health department for a year, not counting the sanitary inspection feature of the health work.

Plans have been completed by Frank R. Gentry for an addition to and remodeling a two-story frame and plaster building at Fifteenth and Figueroa streets, converting it into a medical building to be tenanted exclusively by physicians and surgeons. Drs. Myers and Palette are the owners. The old structure will be remodeled to contain waiting rooms and public offices. The addition will be about 55x65 feet, two stories, of frame and plaster construction.

The Chester Montgomery home at Lamanda Park, near Pasadena (a suburb of Los Angeles) has a private swimming pool that ranges in depth from four to some ten feet. When Mrs. Dudley Fulton found her little daughter, Marguerite, lying at the bottom of the pool, the mother instinct made very prompt use of athletic training and excellent swimming ability. Mrs. Fulton dived into the pool, rescued and directed the resuscitation of her child, then realized that she had utterly ruined her fashionable spring outfit. She had plunged into the pool in her full afternoon attire. The child is none the worse for the experience. But the dress— However, we don't wonder that Dr. Fulton is so proud of his wife.

In the shake-up that occurred in the State Board of Dental Examiners in San Francisco, Dr. F. H. Houck of Anaheim was elected president of the board. Three members of the board voted in favor of ousting Dr. C. A. Herrick of San Francisco as secretary of the board. Dr. C. E. Rice of Los Angeles who was president of the examiners, was elected secretary to succeed Dr. Herrick, and Dr. Houck was chosen to fill the vacancy made by this shift. Another important move made by the dental examiners, was to change the office of the board from San Francisco to Los Angeles. A San Francisco dispatch states that one member of the board stated that the reason for deposing Dr. Herrick, who has been secretary for ten years, was that he used arbitrary methods.

At the regular monthly meeting of the Orange County Medical Association held April 4th, Dr. Cushman of Santa Ana was elected president. Dr. Shank of Huntington Beach was elected vice-president; Dr. Dubois of Santa Ana, secretary; Dr. Gordon, Santa Ana, treasurer, and Dr. Ball, Santa Ana, librarian. Doctors Dryer, of Santa Ana and Johnson of Anaheim were elected delegates to the State Medical Association meeting

to be held at Fresno April 18. Doctors Gordon and Ball were elected as alternates.

An interesting paper on "Medical Examinations for Life Insurance" was read by Dr. R. G. Taylor of Los Angeles.

Following the meeting, which was held in the public library, the physicians enjoyed a delightful luncheon at the Dragon.

BOOK REVIEWS

BLOOD-PRESSURE: ITS CLINICAL APPLICATIONS. By George William Norris, A.B., M.D., Assistant Professor of Medicine in the University of Pennsylvania; Visiting Physician to the Pennsylvania Hospital; Assistant Visiting Physician to the University Hospital; Fellow of the College of Physicians of Philadelphia; Member of the Association of American Physicians. Second Edition, Revised and Enlarged. Illustrated with 102 Engravings and 1 Colored Plate. Lea & Febiger, Philadelphia and New York, 1916.

This is considerably larger than the first edition, and embraces a very satisfactory resume of the subject during the past two years, a period quite prolific in literature on blood-pressure. Practically all methods and instruments receive consideration in a clear and lucid manner. It is interesting to note the relative advantages of the different methods. In order to obtain the greatest accuracy (as in experimental work) and for the purpose of having permanent demonstrable records the **graphic method** excels. For routine clinical work where simplicity and celerity, combined with reasonable accuracy, are the chief desiderata, the **auscultatory method** is to be preferred. The older **palpatory method** offers more chance for error, due to the personal equation, and with it much more difficulty is experienced in determining the diastolic pressure. Furthermore, the auscultatory method has to a considerable extent eliminated the question, "Which sphygmomanometer shall I buy?" because with the last named method any accurate manometer, if

supplied with a suitable 12 cm. cuff, etc., will answer the purpose. The **sphygmographic attachment** at the wrist, aside from being troublesome to adjust, results in venous stasis, which elevates the curve and diminishes the excursions. The **oscillatory devices** have the disadvantage that the eye has to measure two different points at once. They are useful, however, when the pulse is small, and some of them can be used to register the pulsation in the smaller arteries. So far as clinical accuracy is concerned, it is not of great moment which method is employed. The results will generally not vary more than 10 mm. Hg., figures well within the range of allowable error. These clinical methods are after all only relative estimations, and if the same instrument is used in all cases, and the examiner is conversant with the technique, the results will be sufficiently accurate for comparison and for practical purposes generally. Considerable space is devoted to the blood-pressure in various diseases, a subject with which Norris is eminently able to deal, and this feature adds very greatly to the practical value of the work to the practicing physician.

THE MEDICAL CLINICS OF CHICAGO. Volume I, Number IV (May, 1916). Octavo of 229 pages, 22 illustrations. Philadelphia and London: W. B. Saunders Company, 1916. Published Bi-Monthly. Price per year: Paper, \$8.00; Cloth, \$12.00.

This issue contains an article by Dr. Walter W. Hamburger, giving the results

of a modification of the Allen treatment of diabetes in the Cook County Hospital. The method of starvation, tolerance testing and after-care are given. We would suggest that there is a vast difference between glycosuria and diabetes. It has long been known that sugar will disappear from the urine of diabetics kept upon a sugar-free diet, but it is often a serious question whether such treatment is universally applicable. Many diabetics do not do well upon an absolute sugar-free diet. Furthermore, it is doubtful whether the Allen treatment or this modification, offer sufficient support for the diabetic patient. However, the 14 cases here related showed improvement under prolonged fasting.

LATERAL CURVATURE OF THE SPINE AND ROUND SHOULDERS. By Robert W. Lovett, M.D., Boston. John B. and Buckminster Brown, Professor of Orthopedic Surgery, Harvard Medical School; Surgeon to the Children's Hospital, Boston; Surgeon-in-chief to the Massachusetts Hospital School, Canton; Consulting Orthopedic Surgeon to the Boston Dispensary; Member of the American Orthopedic Association; Corresponding Member of the Royal Society of Physicians, Budapest; Korrespondierendes Mitglied Der Deutschen Gesellschaft Fur Orthopädische Chirurgie, Socio Della Società Italiana Di Ortopedia. Third Edition, Revised and Enlarged with 180 Illustrations. Philadelphia, P. Blakiston's Son & Co., 1012 Walnut Street. Price \$1.75 net.

The treatment of structural scoliosis, lateral curvature with fixed bony changes, is a bone problem that too often is mistreated as a muscle problem. In the gymnastic therapy of such cases, progressive improvement, improvement that persists from one exercise period until the next one, must be assumed as the criterion of efficient treatment. In brief, (1) gymnastics may be given alone as a treatment, or (2) in cases where the patient becomes rapidly flexible or seems to require support between exercises, such treatment may be supplemented by the use of supporting jackets, braces or corsets. (3) In connection with gymnastic treatment, intermittent passive stretching may be useful in restoring flexibility, or (4) both corsets and

stretching may find their use in connection with gymnastics. (5) Finally forcible correction should constitute the treatment of most moderate and all severe cases. It is a good monograph on the subject, that should prove valuable to physicians, medical students and teachers of physical training.

FRACTURES AND DISLOCATIONS, with special reference to their pathology, diagnosis and treatment. By Kellogg Speed, S.B., M.D., F.A.C.S., Associate in Surgery, Northwestern University Medical School; Associate Surgeon Mercy Hospital; Attending Surgeon, Cook County and Provident Hospitals, Chicago. Illustrated with 656 engravings. Lea & Febiger, Philadelphia and New York. 1916. Cloth, \$6.00 net.

In the preparation of this work, much of the clinical and all of the statistical material has been obtained at the Cook County Hospital, Chicago. The author has carefully culled from the literature the information which seemed most helpful and with it has combined his own ideas and experience. The author has selected examples of different types of usual fracture pathology and has brought them before the reader's eye by means of line drawings which illustrate the essential points. A study of the line drawings in this excellent treatise is decidedly educational. Every illustration of this character is a careful reproduction of a tracing made from a Roentgenogram of an actual case. If you are interested in fractures and dislocations, you can ill afford to do without this volume of 888 pages.

THE CLINICS OF JOHN B. MURPHY at Mercy Hospital, Chicago. April, 1916. Published bi-monthly by J. B. Saunders Company, Philadelphia and London. Price \$8.00 per year.

This number contains the usual assortment of excellent surgical "cases." Of special interest is A Talk on the Surgery of Tendons and Tendon-Sheaths, to which subject 22 pages are devoted. We would also call special attention to A Collective Review on Surgery of Cervical Rib.

RULES FOR RECOVERY FROM PULMONARY TUBERCULOSIS. A Layman's Handbook on Treatment. By Lawrason Brown, M.D., of Saranac Lake, N. Y. Second edition, revised and enlarged. 12mo, 184 pages. Cloth, \$1.25 net. Lea & Febiger, Publishers, Philadelphia and New York, 1916.

The first edition of this valuable handbook for laymen met with a prompt and wide acceptance and was soon exhausted. Having for years been associated with the late Dr. Trudeau in his tuberculosis work at Saranac Lake, New York, Dr. Brown

knows the problems which confront the consumptive who would live a life that shall make him an acceptable member of society, rather than a person to be shunned. If a permanent cure is to be effected, it is necessary that the patient shall learn how to co-operate intelligently with those who prescribe and care for him. This handbook gives in brief and simple form all that is necessary for the patient to know in order to render such co-operation.

MISCELLANEOUS

MISS WIER—AN APPRECIATION

The sad news of the death of Miss Jessie Wier, May 26th, at Quaker Hill St., has been received. Miss Wier was for many years librarian of the Barlow Medical Library, where she made many friends. The following is from Dr. Stanley P. Black:—

Miss Wier was associated with the Barlow Medical Library almost from its inception, first as a voluntary assistant and later as full librarian. She has been devoted to the Library and has always striven to see that all of its advantages were fully offered to the profession. No personal sacrifice was too great for the Library or its patrons. When she resigned about a year ago, she did so very reluctantly. She had however always promised a friend with whom she had been intimate from childhood, that she would do anything the friend wished if she would come out here to live. The friend wanted her to quit the Library and go into business with her in Hollywood. The separation from the Library was to her like that from an old friend and she felt it keenly.

The medical profession of Los Angeles and the surrounding territory owe a debt of gratitude to her memory for her painstaking efforts in their interests.

ANNUAL MEETING OF THE AMERICAN MEDICAL EDITORS' ASSOCIATION

The annual meeting of this Association will meet at the McAlpin Hotel, New York City, on October 25th and 26th.

A most interesting programme is in course of preparation and the Local Committee composed of the following members is an assurance of a successful convention.

Dr. Thomas L. Stedman, (Editor, Med'l Record) Chairman

Dr. R. H. Sayre, (New York Medical Journal)

Dr. Brooks H. Wells, (Editor, Amer. Jr'l of Obstetrics)

Dr. Frank C. Lewis, (Internat'l Jr'l of Surgery)

Dr. Ira S. Wile, (American Medicine)

The Officers of the Association for 1915 and 1916 are as follows:

Dr. Edw'd C. Register, President
(Charlotte Med'l Journal, Charlotte, N. C.)

Dr. W. A. Jones, 1st Vice-President
(Journal Lancet, Minneapolis, Minn.)

Dr. G. M. Piersol, 2nd Vice-President
(Amer. Jr'l Med'l Sciences, Philadelphia, Pa.)

Dr. J. McDonald, Jr., Secretary & Treasurer.
(American Journal of Surgery, New York)

Executive Committee

Dr. C. F. Taylor, (Medical World, Philadelphia, Pa.)

Dr. John C. MacEvitt, (N. Y. State Jr'l of Medicine, New York)

Dr. A. S. Burdick, (Amer. Jr'l of Clin. Med, Chicago, Ills.)

Dr. Joseph MacDonald, Jr., (Amer. Jr'l of Surgery, New York)

The meeting on October 25th and 26th will be devoted exclusively to problems of a strictly journalistic nature, which will be of importance and interest to every editor and publisher of a medical journal. Among the papers to be presented are the following: "Editorial Control"—"The Editor's Prerogative in Editing Original Articles"—"Book Reviews in Medical Journal"—"Problems of the Subscription Department"—"The Relationship Between Medical Journals of the Day"—"The Up-Lift in Medical Journalism"—"The Influence of the Medical Press and Profession in Public Affairs"—"The Rights of an Author in the Disposition of his Contribution"—etc.

WARNING

We are advised that a very clever swindle is being worked by a young man calling on physicians in various sections of the country. He is fraudulently soliciting orders and collecting money for subscriptions to medical journals and for medical books published by various firms. He usually represents himself as a student, working his way through college and trying to get a number of votes to help him win a certain contest. He sometimes uses the names of L. D. Grant, H. E. Peters, R. A. Douglas and F. C. Schneider and he usually gives a receipt bearing the heading of some Society or Association, such as United Students Aid Society; the Alumni Educational League; the American Association for Education, etc.

The description given of this swindler

is—young man of the Jewish type, rather slender, with very dark hair combed straight back and shows his teeth plainly when talking.

The whole scheme is a fraud. The Societies mentioned do not exist. The idea is to collect money by offering special discounts and prices on medical books and journals and skip with the money.

This young man does not represent W. B. Saunders Company, whose name he frequently uses. He is a fraudulent subscription agent and physicians, generally, should be on the lookout for him.

CHIROTHERETIC

(From the Fresno, Cal., Republican)

One T. F. Ratledge, a chiropractic practitioner of Los Angeles, recently convicted for practicing without a license, refuses a pardon which he claims was offered him on condition that he go before the State board and get a license, and insists instead on serving 90 days in jail to "vindicate" the right of chiropractics to chiropractice on their own chiropractical self-certification. He makes the specious plea that since the chiropractics do not administer "medicine," they ought not to be certified by a "medical" board.

The plea is a pure play on words. The State "medical" board has on it an even disproportionally large representation of the various alleged "schools," including "drugless" ones, and in its "medical" examination of "Dr." Ratledge it would require of him no knowledge at all of "medicine"—if by "medicine" is meant the giving of drugs. But it would require him, if he is going to treat the stomach, even by thumping the backbone, to know where the stomach is, and what happens to the food that goes into it. If he is going to treat a serous exudation of the pleural membrane by twisting the fifth dorsal vertebra, he must at least know where the pleural membrane is, and how to tell whether it is a serous exudation that is the matter with it. If he is going to absorb a duodenal carcinoma by per-

cussion of the dorsal process of the fourth lumbar vertebra, he must, at least, know where the duodenum is, and how a carcinoma grows. This knowledge may not be chiropractically necessary for chirothumpic or chirotwistic technique in doing the actual chirobumping, but it should at least be useful in finding out where and what the trouble is, and in determining what sort of chiropercussive or chirotractic manipulation the particular case requires.

On these things, and on his general knowledge of the structure and the normal and abnormal processes of the human body, not on the composition and dosage of drugs, the "medical" board would examine him. And they would require of him exactly half the knowledge of his trade that they require of the "medical" doctor. If "Dr." Ratledge has that half-knowledge, he can get himself certified by showing it. If he has not that half knowledge, then the community is safer from his ignorance while he serves his voluntary chirophenal term in jail.

K-Y LUBRICANT

Physiological Friction is of double disadvantage. To the patient it brings discomfort, pain and sometimes severe suffering. It sometimes causes the doctor to lose some of his usual deftness and thus impresses his patient that he is careless—or not as skilled in manipulation as he might or ought to be.

And Physiological Friction is further to be regretted because—it is so easily avoidable in most instances.

A skidding sound hurts, but when well lubricated with K-Y Lubricating Jelly, which is Friction's Antidote, it slips securely along its accustomed or intended track.

A dragging rectal or stomach tube, strains the patient's forbearance, and often makes the dread of repetition so strong as to postpone or abandon subsequent calls.

An examining finger hurts—unless perfectly lubricated, and the word per-

fectly does not admit of grease or oily substances.

For grease is not an ideal agent for this purpose—it soils the patient's clothing, prejudices the doctor's reputation for consideration, and marks the user as being unprogressive and careless.

K-Y Lubricating Jelly is Friction's Antidote.

Because K-Y Lubricating Jelly is slippery—not sticky—and therefore easily adapted for lubricating instruments of penetration.

It is greaseless and water-soluble, not only clean and easy to apply, but non-soiling and removable by even cold water without soap.

The very properties that render K-Y Lubricating Jelly a perfect lubricant, make it emollient and protective.

Furthermore, K-Y Lubricating Jelly is to a striking degree **soothing**.

Applied after a burn or a "chafe" it relieves promptly and hastens healing.

In pruritus—even in severe forms of genital, anal, diabetic, eczematous itching, K-Y Lubricating Jelly will, in a great majority of cases, bring relief, or at least grateful alleviation.

To anoint the skin in scarlet fever, measles, chicken pox, K-Y Lubricating Jelly is not only effective, but convenient and economical, since it can be used without staining or soiling the bed clothes or the patient's linen.

One use in particular will appeal to the surgeon, K-Y Lubricating Jelly makes the hands soft and supple—prevents bichloride rashes and "improves the feel."

A PLEA TO LICENSE IGNORANCE

(From the Fresno Republican)

One P. L. Crane, a drugless healer of Los Angeles, has brought suit in the United States District Court to set aside the medical practice act of California, on the ground that it illegally discriminates against certain classes of drugless practitioners, by imposing on them "harsh, discriminatory, unreasonable and prohibitory conditions." It is stated

that the suit will be backed by some 700 drugless practitioners and numerous and eminent counsel.

Inasmuch as the only "harsh, discriminatory, unreasonable and prohibitory condition" imposed by the law is the requirement that these healers shall have studied the art which they profess to practice, it is not likely that their contention will get much further with the courts than it did with the people. These practitioners have twice submitted to the voters, proposals that they be permitted to undertake to repair the human frame without first having studied that frame, and they have twice been overwhelmingly defeated. They have submitted the same contention to successive legislatures, and have been uniformly turned down. Now they appeal to the courts, to grant them a right which both the legislature and the people have refused them.

Unfairness of Present Law

Actually, the only "discrimination" in the law is not against, but in favor of these drugless healers. The law requires that no person shall undertake the physical care of sick bodies without having a certain minimum of general education and of special study of the structure and processes of the organism he proposes to treat. But the law provides that if he practices without drugs, he needs to have only half as much training as is required of the practitioner who uses drugs, and if he uses prayer or other spiritual means, he does not need to know anything at all. This is certainly discrimination enough. It excludes only those who use physical manipulation, and who lack even the little schooling in that manipulation required of its practitioners.

The case, then, is a plea for ignorance in the healing art. A stationary engineer, to run an engine is required to show that he knows what is in the engine and how it runs. The courts are now asked to say that the state has no right to impose a similar educational requirement on those who undertake the repair of badly working human bodies.

A NOTABLE GERMICIDE

It is becoming more and more apparent as time passes, that in Silvol we have a germicide of uncommon usefulness. Its field embraces practically all inflammations of mucous membranes. The indications for Silvol include conjunctivitis, corneal ulcer, trachoma, rhinitis, sinus infections, otitis media, pharyngitis, tonsillitis, laryngitis, gonorrhoea, cystitis, posterior urethritis, vaginitis, cervical erosions, endometritis, etc.—all infections, in short, in which a silver salt is applicable.

Silvol would appear to have a number of advantages over most of the other proteid-silver compounds. It is freely soluble in water. While an exceptionally powerful antiseptic, it is non-irritating in ordinary dilutions. Silvol solutions are not precipitated by proteids or alkalies or any of the reagents that commonly affect other silver compounds in solution. They do not coagulate albumin or precipitate the chlorides when applied to living tissue.

In the treatment of acute inflammations of mucous membrane, Silvol may be used locally in solutions as strong as 50 per cent with very little pain or irritation. In inflammatory affections of the ear, nose and throat it may be used in 5-to-40-per-cent solution, and for irrigating sinuses a 2-to-5-per-cent solution may be employed with benefit. For inflammatory conditions of the eye and conjunctival infection with pneumococci and staphylococci, a 10-to-40-per-cent solution may be applied with benefit three times a day. In acute gonorrhoea, as an abortive measure, a 20-per-cent solution should be injected every three hours, while in the routine treatment the injection of a 5-per-cent solution three times a day is recommended.

Silvol is a Parke, Davis & Co. product. It is supplied in ounce bottles and in bottles of 50 capsules, each capsule containing 6 grains; also in ointment form (5-per-cent Silvol) in collapsible tubes containing approximately $\frac{1}{8}$ ounce and $1\frac{1}{4}$ ounces.

PRICES OF DRUGS UP 50 TO 3000 PER CENT

Permanganate of Potash, Carbolic Acid, Castor Oil, Cost Real Money

War is certainly living up to the expectation given it by General Sherman.

That is what the druggist thinks when he goes to buy his supplies from the wholesaler.

The customer when he buys in retail quantities thinks the same thing.

Since the European war began, ordinary drugs have gone up in price from 50 to 3000 per cent, depending on the article, according to figures obtained today in Los Angeles.

Want a little castor oil for the baby? Sure. Well, since the war started the price has increased something like 250 per cent.

How about carbolic acid? The increase is only about 1300 per cent.

Suppose you buy a little boric acid. You pay just 100 per cent more for it now than you did in 1914.

Save Your Strychnine

Strychnine is only a little more than twice as expensive now.

Benzoate of soda costs \$5 a pound more now than it did two years ago, while permanganate of potash has soared nearly 3000 per cent in cost.

Aspirin is double the price it used to be.

Calomel now costs about seven times as much as in 1914, while practically all the potassium compounds are establishing a new altitude record that an aviator might envy.

Take Less Chloroform

Glycerine has trebled in price. Epsom salts are more than doubled and chloroform has nearly quadrupled in price.

Acetanilid in 1914 cost around 20 cents a pound. Now it is well above \$2.

Bromide of soda has jumped from below 50 cents a pound to \$4.75.

Quinine sulphate is about five times as high now as it was.

Evidently witch hazel neither comes from abroad nor is used in making war munitions, for it is only a few cents a

gallon higher than formerly. But through a long list of drugs a big increase in price is seen, and, according to druggists, indications are that the top has not been reached yet.

WOMANS' MEDICAL FRATERNITY

Kappa chapter of Alpha Epsilon Iota, Womans' Medical Fraternity, was entertained at the home of Dr. Cynthia Skinner, No. 878 Riverside drive, Mt. Washington, April 28th. The feature of the evening was a "children's frock party," which was participated in by all the guests. An elaborate dinner was served at 6 o'clock, after which the real fun of the evening began.

The grand prize was given to Dr. Mary Noble as a result of her clever imitation of a 10-year-old child; she was fittingly dressed for the occasion.

Among those present were Drs. Skinner, Zuber, Seymour, Brown, Kearney, Armstrong, Noble, Peters, Frank, Scholl, Dunsmoor, Hayes, Horstmann, McNeile, Misses Jessica Skinner, Frost, Parks and Mrs. Edy.

WOMAN, REVIVED BY AMMONIA ACCUSES HER GOOD SAMARITAN

**"That's Man Who Ran Me Down,"
She Screams From Operating Table,
Pointing to Doctor Who Had Mis-
taken Her for Auto Victim**

Dr. William H. Harrison of the Emergency Hospital service several nights ago experienced a narrow escape from arrest for violating the "hit-and-run" law. He played the Good Samaritan role and almost found himself involved in a suit for damages, as well as facing a criminal action.

It happened while he was driving his automobile up Market street. At the corner of Grant avenue he saw the form of a woman lying prostrate against the curbing. In a flash the good doctor was out of his car kneeling at the side of the patient. She was groaning as though in mortal pain, and rather than waste time there for further examination, he placed her gently in the tonneau of his car. Then

he went full speed ahead, and in a jiffy was at the Central Emergency Hospital.

"Automobile case," he announced sharply to the stewards, as he carried the victim into the operating room.

"Looks bad," he said, as the examination commenced.

Before long, however, he changed his opinion. A thorough search revealed nothing more than a bad case of alcoholism.

"The ammonia bottle," ordered the disgusted physician.

Two waves of this restorative under the nostrils of the woman brought her upright on the operating table with a startling jerk. Her eyes fell on Harrison.

"That's him," she screamed. "That's the man who run me down. Hold him! He's almost killed me!"

They did their best at the hospital to convince the woman that she was uninjured, and that Dr. Harrison had only figured as her rescuer, but she finally departed, muttering harsh accusations against Harrison.

"Never again!" says Harrison.

DEATH RATE AND EXPECTATION OF LIFE

Director Sam. L. Rogers, of the Bureau of the Census, Department of Commerce, is soon to issue a unique set of tables, the first of their kind which have ever been prepared by the United States Government. These tables, which were compiled in the division of vital statistics, under the supervision of Professor James W. Glover, of the University of Michigan, show death rates and expectation of life at all ages for the population of the six New England states, New York, New Jersey, Indiana, Michigan, and the District of Columbia (the original death-registration states) on the basis of the population in 1910 and the mortality for the three years 1909, 1910, and 1911. They are similar to the "life tables" prepared by life insurance companies, but differ from them in that they relate to the entire population of the area covered, whereas the life insurance tables relate

only to risks selected through medical examination and otherwise.

Expectation of life, at birth, in a stationary population—that is, one in which the births and deaths were equal and were the same from year to year, and in which there was no immigration or emigration—would be the same as average age at death, which is calculated by totalizing the ages of all deceased persons and dividing the result by the number of deceased persons.

Women Live Longer Than Men

According to these tables the average expectation of life, at birth, for males is 49.9 years; for females, 53.2 years; for white males, 50.2 years; for white females, 53.6 years; for native white males 50.6 years; for native white females, 54.2 years; for Negro males, 34.1 years; and for Negro females, 37.7 years. Females are thus longer lived than males to the extent of more than 3 years, and in the case of the native whites and Negroes, more than $3\frac{1}{2}$ years.

The expectation of life at the age of 1 is considerably greater than at birth, being 56.8 years for native white males and 59.5 for native white females, and reaches its maximum at the age of 2, when it is 57.5 for the former class and 60.1 for the latter. At the age of 12 the average native white male's expectation of life is 50.2 years; at 25 it is 39.4 years; at 40, 28.3 years; at 50, 21.2 years; at 60, 14.6 years; at 70, 9.1 years; and at 80, 5.2 years. Similarly, at the age of 12 the average native white female's expectation of life is 52.6 years; at 25 it is 41.8 years; at 40, 30.3 years; at 50, 22.8 years; at 60, 15.8 years; at 70, 9.8 years; and at 80, 5.5 years.

A part of the difference between expectation of life for men and for women is due to the greater number of violent deaths among men. Nearly four-fifths of these violent deaths—suicides, homicides, and accidental deaths—are of males, and such deaths form about 7 or 8 per cent of the total number occurring each year. This fact, however, does not account

fully, or even in major part, for the greater longevity of women. An examination of the tables discloses a lower death rate for females than for males during each of the first 12 months of life and, in the case of the native whites, during each year of life up to the age of 94. During the first month of life the death rate among native whites is nearly 28 per cent higher for boys than for girls, and during the first year it is more than 20 per cent higher.

Infant Mortality Still High

The enormous waste of infant life which still goes on, although medical science has done and is doing much to arrest it, is shown by the exceedingly high death rates which prevail among infants under 1 year of age. Of 100,000 native white boy babies born alive, 4,975, or almost 5 per cent, die during the first month, and 12,602, or 12.6 per cent, die within one year. The girl baby's chance of life is considerably better, the death rate among native white females during the first month being 3,894 per 100,000 born alive, or less than 4 per cent, and during the first year 10,460 per 100,000, or nearly 10.5 per cent.

On its first birthday, however, the likelihood that a child will die within the year is only about one-fourth as great as it was at birth, the death rate among native whites during the second year being 2,841 per 100,000 for males and 2,610 per 100,000 for females. The rate continues to decrease until the twelfth year of life—that is, the period between the eleventh and twelfth birthdays—during which it is only 228 per 100,000 for males and 198 per 100,000 for females. This, the figures indicate, is the healthiest year of life among native whites. Whereafter there is a continuous increase in the death rate from year to year. During the forty-eighth year of life, in the case of native white males, it is 1,267 per 100,000 or almost exactly what it was during the third year, 1,266; during the sixty-second year it is 2,919 per 100,000, or a little

more than during the second year, 2,841; and during the eightieth year it is 12,184 or somewhat less than during the first year, 12,602. Similarly, among native white females the rate during the fiftieth year, 1,120, is a little less than during the third year, 1,144; during the sixty-third year it is 2,548, or somewhat less than during the second, 2,610; and during the eightieth it is 10,901 per 100,000, or a little more than during the first, 10,460. The native white man at the age of 102 and the native white woman at 99 have approximately the same prospect of dying within one month that they had at birth.

Median Age At Death

To say that a person's expectation of life is a certain number of years is not the same as saying that he has an even chance of living that number of years. This is because, as already explained, expectation of life represents the average remaining length of life, at any given age, in a stationary population, whereas an average person in a given group has an even chance of living to what is called the median age at death, that is, the age below which half of the members of that group will die. The median age at death for all native white males in the assumed stationary population would be 60; that is to say, of a given number of such males born alive, half would die before reaching 60 and the other half at 60 and beyond. A native white male child at birth, then, has one chance in two of reaching this age. At the end of his first year, however, he has a trifle better than an even chance of reaching 64; and at 42 he has one chance in two of attaining three score and ten. Similarly, a native white female child at birth has an even chance of living a few months past the age of 64; at the age of 1 she has one chance in two of living until she is nearly 68 years old; and at 22 her chance of reaching 70 is an even one. Thus a native white man at 42 and a native white woman at 22 have about the same chances of celebrating their seventieth birthdays.

City and Country

The relative healthfulness of city and country is strikingly shown by the tables, according to which the death rate among white males under 1 year of age in cities having 8,000 inhabitants and over in 1909, and in cities of 10,000 and over in 1910 and 1911, is 13,380 per 100,000 born alive, whereas in smaller places the corresponding rate is only 10,326 per 100,000, or 23 per cent less than the rate for cities. A similar difference prevails with respect to white females under 1 year of age, for whom the death rate in cities is 11,123 per 100,000 born alive, while in rural localities it is only 8,497 per 100,000, or 24 per cent less than the urban rate.

For white males the expectation of life, at birth, in rural localities is 7.7 years greater than in cities; at the age of 10, 5.4 years greater; and until the age of 39 is reached there is a margin of more than five years in favor of the country. Thereafter the difference becomes gradually less, but is always in favor of the country until the age of 88 is reached, at and after which the cities show a slightly greater longevity than the rural localities.

For white females the difference between urban and rural longevity, while pronounced, is somewhat less than in the case of males. At birth the white female's expectation of life is 6 years greater in rural than in urban localities; at 10, 3.3 years greater; and until the age of 46 is attained the difference continues to be more than 3 years. Thereafter it declines until the age of 83 is reached, after which the cities have a slight advantage over the country.

ORDINANCES OF INTEREST

Ordinance No. 34,294

(New Series)

An Ordinance amending Section 15 of Ordinance No. 30,619 (New Series), entitled "An Ordinance providing health sanitary and quarantine regulations", approved August 13th, 1914.

The Mayor and Council of the City of Los Angeles do ordain as follows:

Section 1. That Section 15 of Ordinance No. 30,619 (New Series), entitled, "An Ordinance providing health, sanitary and quarantine regulations", approved August 13th, 1914, be, and the same is hereby, amended so as to read as follows:

Sec. 15. It shall be unlawful for any person to remove, or to cause to be removed, or to assist in removing, or to direct the removal of any person affected with bubonic plague, Asiatic cholera, smallpox, typhus fever, yellow fever, scarlet fever, glanders, leprosy, poliomyelitis, cerebro-spinal meningitis, diphtheria, or any quarantinable disease from any house or place to another house or place without first obtaining a permit in writing so to do, signed by the Health Commissioner.

It shall be unlawful for any person to drive or use, or to cause or permit to be driven or used, any vehicle for the conveyance or removal of any person affected with any such disease without first obtaining a permit in writing so to do, signed by the Health Commissioner.

It shall be unlawful for any person, firm or corporation to remove, haul or convey, or to cause or permit to be removed, hauled or conveyed the body of any dead person in any ambulance or other vehicle which is used for removing, hauling or conveying any sick or injured person.

Sec. 2. The City Clerk shall certify to the passage of this ordinance by a unanimous vote and cause the same to be published once in The Los Angeles Daily Journal.

I hereby certify that the foregoing ordinance was passed by the Council of the City of Los Angeles by the unanimous vote of all the members of said Council present, there being not less than seven members present, at its meeting of June 2, 1916.

CHAS. L. WILDE,

City Clerk.

Approved this 2nd day of June, 1916.

C. E. SEBASTIAN,

Mayor.

Ordinance No. 34,292
(New Series)

An Ordinance authorizing the execution and delivery of quit claim deed to certain lands in the City of Los Angeles to The Barlow Sanatorium Association, a corporation.

The Mayor and Council of the City of Los Angeles do ordain as follows:

Section 1. That the Mayor of the City of Los Angeles, in the name of and on behalf of said city, be, and he is hereby authorized and directed to execute and deliver a quit claim deed to The Barlow Sanatorium Association, to all of the estate, right, title and interest of the City of Los Angeles, in and to those certain pieces or parcels of land situate in the City of Los Angeles, County of Los Angeles, State of California, described as follows, to wit:

All of that certain parcel of land known as Chavez Ravine Road or Chaves Ravine Road, extending from the northeasterly line of Lot 8, of Block 41 of the 35 Acre Tracts of the Los Angeles City Lands, Hancock's Survey, situate on the southern slope of the Stone Quarry Hills, as per map recorded in Book 1, pages 467 and 468, Miscellaneous Records of Los Angeles County, to the northwesterly line of Boylston Street, and lying between those two portions of said Lot 8 described in that certain deed conveying said portions of Lot 8 from the City of Los Angeles to J. B. Lankershim as recorded in Book 528, page 175 of Deeds, records of Los Angeles County.

Sec. 2. The City Clerk of said city is hereby authorized and directed to affix the seal of said city to said deed and to deliver the same to The Barlow Sanatorium Association, a corporation, upon payment by it into the City Treasury of the City of Los Angeles, of the sum of one dollar.

Sec. 3. The City Clerk shall certify to the passage of this ordinance by a unanimous vote and cause the same to be published once in The Los Angeles Daily Journal.

I hereby certify that the foregoing ordinance was passed by the Council of the City of Los Angeles by the unanimous vote of all the members of said Council present, there being not less than seven members present, at its meeting of May 31, 1916.

CHAS. L. WILDE,
City Clerk.

Approved this 1st day of June, 1916.

C. E. SEBASTIAN,
Mayor.

**FOES OF VIVISECTION FORM
ORGANIZATION**

Organization of the San Francisco Anti-Vivisection Society was perfected at the St. Francis hotel April 17th. Formation of the society is in line with a State-wide campaign to bring about legislation designed to prohibit indiscriminate vivisection of humans and animals. It is proposed by the propaganda to acquaint the public generally with the horrors of vivisection. Between now and the convening of the next legislature a systematic campaign will be made to arouse sentiment that will compel the enactment of laws aimed at vivisection. Assemblyman George Gelder of Berkeley was chosen president of the society. Mrs. Rosamond Wright of Los Angeles, one of the leaders in the anti-vivisection movement in California, and Mrs. Phoebe Hearst were elected honorary vice-presidents. Other officers are: Mrs. Walter Manchester, vice-president; Mrs. M. C. Trowbridge, secretary; Dr. Allen Pearson, treasurer; directors, A. E. West, Walter Manchester, Mrs. E. J. Cromwell, Frank Schilling, Miss Mary McCloskey, Miss Grace Ronald and Miss Hilda Smith and Miss Annette Deaner, both of Oakland. Several speakers at last night's meeting denounced the practice of students at the Affiliated Colleges in obtaining, by purchase or otherwise, pet dogs for purposes of vivisection.

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On the contrary, it retards bacterial development, and by reason of its lubricating properties assists in the expulsion of such bacterial poison as may have formed in the alimentary tract.

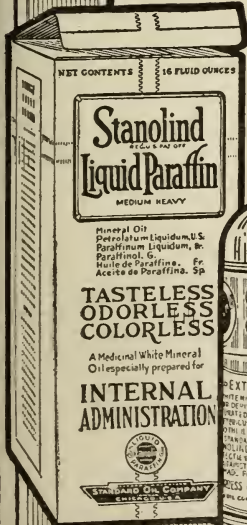
Stanolind Liquid Paraffin not only expedites the movement of fecal matter through the intestines without irritation, but at the same time soothes the tissues.

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WHY NOT?

When it came to opening bids for the letting of the job of county physician of Yuma at the board meeting there was apparently but one bid—at least but one envelop which smelled like medicine. But when this envelop was opened it was found to contain four bids, including all the old line physicians in Yuma. And each one had, in effect, set down the fact over his own signature that if the "deer peepul" of Yuma county wished to have their indigent population cared for by a Yuma physician they must pay the sum of \$150 per month, or \$1800 per year. The four physicians who thus pooled their bids were: Dr. Henri ApJohn, Dr. J. A. Ketcherside, Dr. H. H. Knotts and Dr. C. E. Rooney. It was another way of notifying the board that the Yuma doctors had struck for higher wages; that they had organized a trust with the idea of "bringing the county to its milk," or words to this effect. But the board could not see it that way, and sooner than it takes to write the words, the two mem-

bers present voted to reject each and every one of the pooled bids. The salary of county physician now is \$60 per month. Dr. C. E. Rooney is filling the unexpired term of Dr. E. C. Wills, who moved to Nogales leaving the office vacant. He will doubtless hold over, until the board shall have named a successor.

The board appointed Mrs. Anna Israel Nettle as physician for the northern part of the county, her home being at Parker.

HOT BATHS

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SOUTHERN CALIFORNIA PRACTITIONER.

Vol. XXXI.

LOS ANGELES, JULY, 1916

No. 7

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PROPHYLAXIS OF SPEECH DEFECTS.

BY C. G. STIVERS, M.D., LOS ANGELES.

The subject of speech defects is usually considered a very special branch of a specialty, and it is true that only those with special fitness and training in the handling of children, should be entrusted with the care of the child with a defect of speech. However, it is to the general practitioner that we must look for the recognition and prevention of most of our cases, because as in so many other disorders, he is the first one to see the tendency, and should be the first one to warn parents against the development of lisping, a wholly preventable disorder, and stammering, usually preventable.

Parents should be warned not to give a wrong pronunciation to words the baby first hears. It is equivalent to learning two languages for a child to grow up with a speech defect, and the harm is incalculable when we consider

that the child knows he is not like other children, grows morbid and fretful and develops psychical unbalance. Besides, he is backward in school, from 2 to 3 years in the grades.

65% of school children have some defect that hinders education. Unprogressive children are called repeaters, that is, they keep repeating their studies, taking them over. It costs \$100,000,000 a year to educate 3,000,000 repeating American children. This is mostly unnecessary as only about 3% are mentally defective.

Over 50% of all such defects are easily preventable and all parents, teachers and family physicians should have an elementary idea of speech prophylactics in order that all children on first going to school should begin their studies on an equal basis, and not handicapped by lisping and stammering. There are no

statistics on the subject of Los Angeles schools, but statistics showed in 1912 that 1%, and possibly more, of the school children of San Francisco were stutterers. Los Angeles has probably the same per cent, so that out of our average daily attendance of 65,000 school children 650 are stutterers. Ten per cent more have some other form of speech defect. How much does this cost Los Angeles Taxpayers? It is estimated to cost \$50 a year to keep a child in school. This is represented by Teachers' salaries, etc. A child with a speech defect is retarded 2 to 3 years, so that if 10% are retarded in our schools this means that 6500 scholars are costing the taxpayers of Los Angeles County 6500 times \$50, or \$325,000 every year more than it would if there were no speech defects. This is a large sum of money to lose on account of lack of care or because of foolishly sentimental parents who insist on talking so-called "Baby talk" to their children. Why should a baby learn by imitation that its food (milk) is "dindin" or "mi-mi" or "bah-bah" (bottle), only to learn when older by hearing others talk that milk is milk, and that its parents were silly? **The etiology of speech defects** is as complex as are the clinical features. Temperament is perhaps one of the chief predisposing causes. Phlegmatic quiet children do not stammer. Heredity and environment play important roles. If the parents are of a nervous type they are apt to talk too fast, dispute, argue and otherwise disturb that equability so essential to the normal development of the child. Stammerers are not weak minded, on the contrary, they are usually quick and bright. It is not on account of stupidity that they are from 2 to 3 years behind the normal child, but because their physical infirmities make it impossible for them to keep up.

Starting in at school is often the cause for the development or exaggeration of many speech defects. The new environment, the confusion, the assumption of

new duties, new playmates, thoughts, duties and habits often change what was a mere tendency to linguistic unbalance to a well defined defect of speech. Large adenoids are a well known cause, and their removal often relieves and sometimes cures defective speech. School statistics show 71% of boys and 29% of girls. There are various reasons for this. Boys, the world over, are held to be of more importance economically than girls, they receive more and better attention and have defects if any discovered sooner. Boys grown to manhood must go out into the world and overcome all sorts of obstacles to make a living, whereas girls have always enjoyed a more sheltered life. They are not so handicapped by a speech defect as boys, because they can fill the roles in which normal speech is not of such vital import as it is in men. It does not detract from the efficiency of cooks, chamber maids, dairymaids and women farmers, for them to stammer, because the efficiency of their lives in their contact with the world at large does not depend upon perfection of speech. Girls and boys have a costal abdominal type of breathing, after puberty the costal type remains with the girls and her stammer usually subsides, a result almost never seen in boys. What is the explanation? We may say briefly: Girls have more desire to please and to be agreeable and to perfect themselves, so are ever trying to correct imperfections in themselves. They rarely slouch, cramping the breathing space, as do boys.

What can an adult stammerer do for a living? Bookkeeping, picking fruit, ranching, farming, blacksmithing, or other forms of purely manual labor. He is barred from the learned professions, as Horn says, he is a sociological fizzle, morbid, inefficient.

Makuen says that the suggestion that stammering is a form of auditory aphasia or amnesia is the best explanation that has been given. It is the inability on the part of the patient to call up the

auditory verbal images essential to the practical use of words in speech. This explains certain typical phenomena, for instance, stammerers can sing without showing their affliction. Singing is a tone imagery, not a word imagery. Also this theory explains why they can talk well at times and fail at others, speak well when alone and fail in company, talk fluently to lower animals and to persons of a lower mental grade than themselves, who may not understand all that is said and who are not able to talk back. In other words, one's attempts at the verbal imagery necessary to the production of speech may be thwarted by the mental or psychic stress of one's environment. Advantage is taken of this fact to apply counter suggestions of encouragement and explanation in the treatment. **Can stammering be cured?** Gutzman, the great German speech specialist, reported that in 1000 cases treated by him several years ago he achieved 87% permanently cured, 10% very much improved and 3% were not cured. He says, a man who speaks correctly cannot stammer—stutter, is his word, but that is a Germanic difference in words meaning the same thing. Gutzman teaches physiological speech, and when stammerers have learned it they cannot stammer.

Parents, nurses, teachers and general practitioners of medicine should know something about the prevention of speech defects. 1. Speech is imitated sounds, so let the source be as perfect as possible. Let mothers and nurses speak slowly and distinctly. 2. A child should not be forced to listen to and copy the speech of ignorant, uneducated foreigners serving as nurses, maids, cooks, etc. 3. Children in age from the beginning of speech formation (8 to 12 mo.) should find no difficulty with the consonants b, m, p, f, v. Later on when the teeth are fully erupted they can form, with the aid of the tongue and the anterior part of the hard palate, the consonants d, s, i, r, n, t and z.

This should be from 12 months to 2 years. All other sounds made with the tongue and posterior portion of the hard palate, hard g, j, ng, r, k, ch, come last in time, and are very frequently mispronounced. A very good plan to get children acquainted with good speech is to tell them stories and fairy tales in a slow and modulated voice. Questions by the child following the story will develop both thinking and speaking. In the treatment of speech defects at the Parent-Teacher Clinic in Los Angeles, where for the past four years I have conducted a clinic for the treatment of speech defects, I have marked a growing interest in the subject. Having only one clinic a week is very unsatisfactory, and good results are not easy to get with school children. The first year there was very little interest shown, but the interest has grown so that last year (1915-1916) there were 35 new cases, and over 185 treated. Next year, with 2 or 3 clinics per week, and with the new Clinic building, given by the generosity of the late Mr. O. T. Johnson, and his son Mr. F. O. Johnson, offering better facilities, I confidently expect 100 new cases, and 500 treated. Results have been good. Stammering boys in the 7th to 9th grades, from a total inability to answer simple questions, have learned to recite poems, prose, etc. at the commencement exercises of their schools.

It is possible for lispers to receive treatment at home from someone who has the necessary patience with children (rare quality I find). I usually give 2 or 3 treatments per week and give exercises to be practiced every day at home.

Calisthenics, correct breathing and posture, and attention to the general health must not be neglected.

References:—Makuen, Demonstration of Defects of Speech, Penn. Med. Journal 1914.

Horn, The prophylaxis of speech defects, Journal A.M.A. 1911.

THE DIAGNOSIS OF THE INTERNAL SECRETORY DISORDERS.

BY HENRY R. HARROWER, M.D., F.R.S.M. (LOND.) LOS ANGELES, CALIFORNIA.

III.

The Detection of the Minor Thyroid Dyscrasias—Continued.

From what has been said regarding the exciting and predisposing causes of thyroid disorder, it will be clear that the history, both personal and family, is particularly important as in it we may find a strong hint as to the prospective presence of the condition for which we are looking, although we may not always find a basic reason of this character in our anamnesis, for thyroid disturbances have a habit of appearing without the necessary hereditary or even the presumably essential etiologic foundation.

Hypothyroidism may be found at any time during life, from infancy to old age, though it is most common in young persons. The more serious forms are likely to show themselves in infancy or youth, while the forms that are usually overlooked altogether are more usual during the thirty or more years of active reproductive life, and as has been mentioned, it is especially frequent in women.

When we recall the principal intracellular functions of the thyroid hormone, it will be easy to understand that aberrations in the production of this chemical messenger not only interfere with cellular growth, but they derange the essential chemical changes connected with the incessant regeneration of the cells themselves. Their waste products are retained and the effete material is not burned up, facts which are proved in several different ways. The chief result of this special form of suboxidation is the establishment of a condition of **cellular infiltration** which varies both in degree and in the number and location of the organs attacked. That it is often generalized cannot be denied, but that it is more manifest in some tissues is also true, as we shall see when

the results of the more serious forms of thyroid disease are considered.

While the loss of the normal thyroid hormone stimuli may account for many disorders, more clinical symptoms result from this infiltration than from any other single result of thyroid derangement. As we enumerate the symptoms of thyroid disorder this one factor—infiltration—stands out above all the others, and when its importance and extent, as well as the fundamental philosophy of its presence, is thoroughly understood, it will explain many a symptom which previously had not been supposed to have the least to do with this gland. The credit for the discovery and announcement of this phenomenon undoubtedly belongs to my good friend Dr. Eugene Hertoghe, of Antwerp; and to him is due the homage of the medical profession for his remarkable contributions on this subject. The importance of the whole subject may be impressed by a quotation from this eminent authority:* "It is obvious that myxedematous dwarfism and infantile cretinism cannot escape detection by a physician of even moderate attainments. . . .but the slighter forms of thyroid inadequacy are almost invariably missed; yet, owing to their extreme prevalence, the recognition of these is extremely important."—although more than twenty years have passed since the symptomatology of "chronic benign thyroid insufficiency" or "myxedeme fruste" was first described.

This is just as true of the other functional endocrinous disorders, and the fact that they are so very often overlooked, and information as to how to detect them is not easy to obtain, is, it is to be hoped, a sufficiently good reason for this series of articles.

*E. Hertoghe, Thyroid Insufficiency, Practitioner, Jan. 1915, p. 27.

Thyroid insufficiencies are more frequent than the exanthemata. Minor hypothyroidism is among the commonest of disorders. It complicates pediatric problems more often than most other single conditions. It is equally important in the etiology of many functional gynecological troubles as well as in many of the complexities of internal medicine. Neurologists are coming to consider it as a much more vital factor in their difficult cases than has previously been supposed and it may be considered to be an insidious complicating element in many chronic diseases including that symptom-complex which is usually called "neurasthenia" for the lack of a better name.

Close study is always awarded by results which usually have a very definite clinical significance. This is as true in endocrinology as elsewhere; and to the seeing eye is unfolded many an obscure condition of daily occurrence. These are obscure merely because their insidious onset hides them. They have not been looked for. The taking of the clinical history is too often a perfunctory and unsatisfactory procedure—in general practice, at least—though in the "difficult cases" where others have failed previously, a little more care and thought is given. **The secret of success in endocrinology is thoroughness.** It is "the little foxes that spoil the vines"—the little things that count; and it is surprising how the appreciation of a seemingly insignificant circumstance enables us to correlate some other equally insignificant condition, and thus to pass the unseen barrier which has been separating us from a full understanding of a given case.

The processes of cell-exchange, nutritional and eliminative, influence all parts of the body, hence "no tissue is able to escape the results of impoverishment of the thyroid gland." These results are just as real and important from a practical standpoint as many other obscure but none the less important disorders.

They are often even more important' for their very obscurity means that their discovery may be of unusual helpfulness. The fact that they have been overlooked has made a great difference to the treatment and accounts for many failures; and their discovery may put an entirely new aspect upon the prognosis, for the treatment of internal secretory disorders with well marked and organic involvement, is not always as successful as that of those conditions in which only the early functional changes are beginning.

So many organs and systems may be affected by disturbed thyroid secretion that it is necessary to consider separately the principal changes in the different tissues. It should be remarked, however, that not all of the conditions shortly to be enumerated will be found together in a given case, not even in the serious forms of hypothyroidism. The detection of several of them is sufficient ground for the application of suitable thyroid therapy. This is not empirical thyroid medication, for further proof of its scientific basis is forthcoming when the response is favorable, for Hertoghe's statement must be taken as axiomatic that "those who derive benefit from thyroid medication invariably will be found to show symptoms of thyroid inadequacy"; and if thyroid may have been indiscriminately administered—a not infrequent happening—and the results are favorable, this may be taken as a therapeutic-diagnostic test (just as certain treatment was the only definite way to demonstrate the etiology of certain brain tumors, a procedure which is now entirely superceded by the Wassermann reaction.) The most common example of this is the response of some obese individuals to empirical thyroid medication.

As the thyroid plays such an important part in so many of the activities of the body, its functional derangement may result in the commonest of pathological conditions. Inadequate or suppressed thyroid function causes morbid syn-

dromes in direct ratio to the loss of the thyroid hormone to the body; and this may affect almost every tissue and function. Perhaps the most common and constant changes resulting from hypothyroidism are seen in the skin and its appendages. It is infiltrated with waste products, puffy and insufficiently nourished so that it becomes dry, rough and desquamating. Sensible perspiration is reduced and in advanced cases not even exertion in summer heat will awaken the dormant sweat glands. Usually the more marked edema is only present in myxedema, which will be considered later. Many dermatoses may be found. In children eczema is most common; at puberty, especially in girls, acne and in adults herpes, psoriasis, urticaria and dermal malnutrition and susceptibility to slight cutaneous infections with varying symptoms. According to Leopold Levi subthyroidism provides a favorable soil for recurrent erysipelas and he has found that this condition has yielded readily to thyroid.

The hair is sparse, thin and ill nourished, falls out easily and characteristic of certain stages of this condition is the "*signe du sourcil*"—a commencing or absolute loss of the outer third of the eyebrows. The nails are often striated and brittle, later cracking very easily. The teeth are bad, caries being a common result of hypothyroidism.

The temperature is below normal, and occasionally is lower in the late afternoon at which time there may be fits of shivering, at times simulating malaria very much. There is a general chilliness and the extremities are cold. These individuals feel the cold very much and require undue amounts of clothing or bed coverings. They are continually complaining about the cold, take all sorts of precautions to guard against it and slight draughts cause rheumatoid or neuralgic pains. "Dead fingers" are often due to this cause and cyanosis and even chilblains are connected by many

authorities with hypothyroidism. Raynaud's symmetrical gangrene and other forms of vasomotor spasm with skin manifestations are also credited to the same fundamental cause.

Fatigue, especially in the morning, is usual. Subjects of this disorder were "born tired" and require much sleep. They sleep very heavily, often in the day, especially after eating. There is a feeling of depression and well-marked cases are apathetic, disinterested and "lazy."

The infiltration and generally devitalized condition favors obesity. The muscles, joints and ligaments are all influenced, producing such common symptoms as "rheumatism", stiff neck, aching in the limbs and back often between the scapulae. The joints may be stiff and occasional swelling may even suggest ankylosis. Crackling in the joints is not unusual and Hertoghe speaks of it being very common in the knees. The involuntary muscles are also affected, the intestinal and abdominal walls are weak and ptosis is the rule. Stasis, constipation and the accompanying toxemia complete a vicious circle. Many of the symptoms so widely emphasized by Sir Arbutnot Lane were connected and described by Hertoghe 15 years before and definitely credited to "benign chronic subthyroidism".* For many years he has successfully treated such cases on this basis, and while there may be an advantage in the present vogue of intestinal lubrication and rarely, even in the operative measures recommended, the elucidation of the fundamental cause and its removal is a much more satisfying as well as rational procedure. Obstipation is not uncommon. The appetite may be progressively poor and certain foods, especially meat, are intensely disliked. The appearance is toxic and often prematurely senile and in advanced cases a brownish pigmentation of the skin has been remarked.

The heart action is weak and the pulse

*E. Hertoghe, Bull. Acad. Med. de Belg., Mar. 1899, p. 231.

usually slower than normal. Circulation is especially poor, accounting for some of the manifestations (associated with the infiltration) just connected with hypothermia. Respiratory oppression and varying degrees of dyspnea are frequent. Occasionally this is intermittent and mistaken for asthma, thus explaining unexpected cures in "asthma" following thyroid therapy. According to Hertoghe "the physiologic stimulant of the heart is supplied by the thyroid. It is, in a certain sense, the necessary tonic, the normal digitalis, by which cardiac activity is promoted and maintained. . . I do not hesitate to exhibit thyroid extract in cases of weak contractility and tendency to syncope, and I may say that the treatment has never failed me."*

The desquamation so marked on the epidermis, as well as the infiltration and loss of function due to it, is also present in the bladder which, by the way, seems to be peculiarly supersensitive to hypothyroidism. Squamous cells are common among the urinary findings, and the incessant denudation results in an undue sensitiveness to contact with the urine causing frequent urination and enuresis, especially in children who, it will be remembered, are very heavy sleepers (with consequent decreased control over the ejaculator urinae reflex) as a result of which bed-wetting is not unusual. The other urinary findings show the reduced oxidation very plainly. This is especially noticeable in the low urea output. In such cases there is often a tendency to acidosis and an estimation of the ammonia will show that generally it is unduly increased, due to the imperfect metabolism in the liver of the "urea precursors." It almost seems that there is a distinct connection between the thyroid and the liver, for in the more marked cases of hypothyroidism, not only are the chemical functions of the liver disturbed, but it becomes infiltrated, passively congested and tender on pressure. The same is true of the gall bladder

and the desquamation there favors the production of gall stones or jaundice with their usual symptoms.

The mental disturbances are many and varied. Slowness characterizes every form of mental action. The memory becomes gradually poor, there is difficulty in following a line of thought or reasoning. Apathy, somnolence and melancholia and in the more marked cases, organic brain disorders with varying forms of mental deficiency may be present. Headache is a usual and early symptom, especially when early in the day. It is so constant in some cases that they have accustomed themselves to it and "have it all the time." Neuralgia and migraine have been definitely traced to the thyroid and the conclusions verified by the therapeutic test. Two insidious subjective symptoms may be present which are rarely thought of in connection with this disorder. These are giddiness and noises in the ear. The generalized infiltration is again responsible, and the same thing also may cause hoarseness, a change in the timbre of the voice, and even aphonia.

The effects of thyroid dyscrasia on the gonads are well marked and among the most constant findings, especially among women. The subject will be more fully considered in the chapter on "Pluri-glandular Disorders". There are, however, some important conditions which must be referred to here. Early thyroid disorder spells late reproductive activity. Often the menses are delayed for years, or after having started may be suppressed for a varying period. Amenorrhea is sometimes present, especially in young girls; but when the characteristic infiltration is present the reverse is the rule; menorrhagia, severe and persistent, is a common result. It is believed by some that the thyroid has something to do with the development of the uterus, and that when hypothyroidism is fairly well marked the posterior uterine wall is not properly developed, sometimes causing a

*E. Hertoghe, Practitioner, Jan. 1915, p. 54.

marked retroflexion which may be a part of the cause of the menorrhagia. The menses are prolonged, may recommence after they are apparently over, the frequency of the periods is increased and the loss of strength and activity is especially noticeable. "The higher the degree of thyroid inadequacy, the greater the menstrual losses" (Hertoghe.)

Many a case of severe dysmenorrhea has an important thyroid element in its causation, and this factor may outweigh all the other associated conditions. These cases nearly always show one or more of the other symptoms of thyroid inadequacy, and the success of thyroid or thyro-luteal therapy* will be the best proof of the correctness of our surmises.

The principal digestive symptoms in addition to those already mentioned are not well marked. Glandular insufficiency (due both to toxemia and infiltration) may be expected, the stools are hard because of the reduced alimentary secretions and constipation is the rule. I have found emetine very helpful in such cases and I am sure that when endamebiasis is present—it is much more frequent than we have thought—this is simultaneously benefited. A sensation of heaviness over the epigastrium is not unusual and biliary colic has been caused by infiltration and nothing else; and nutrition is below par, though the weight may be normal or, more often, increased. There is a reduction in weight when our therapeutic efforts begin to relieve the infiltrated cells throughout the body of their accumulated wastes. Hertoghe uses the term "thyroid inanition" which refers to a condition of cell starvation, inactivity and asthenia without obvious changes in contour or weight. Vomiting, in some cases, may be due to this same fundamental cause, especially when associated

with pregnancy. (This whole subject will be more thoroughly studied in the chapter on the gonads.)

We have enumerated many symptoms referable to thyroid insufficiency, so many, in fact, that a catalogue of the possible symptoms of this disorder render the cataloguer open to ridicule! The fact remains that they may all occur as a result of this disorder though we may not find more than three or four of these signs in one case. However it is by no means uncommon to find an individual showing what might be called "a classic picture" of hypothyroidism—severe headaches, neuralgia, "rheumatism," constipation, ptosis, skin disorders, hypothermia, chilliness or distinct chills, slight dyspnea perhaps better referred to as a sense of undue oppression on the slightest effort, asthenia, mental changes of a minor character as loss of memory, inability to concentrate, menorrhagia, etc., etc.

Such cases, heretofore an unmitigated nuisance both to their relatives and their physicians—for too often they have perambulated from one physician's office to another—may now be considered as of unusual profit, for their treatment by attention to the necessary hygienic measures plus thyroid therapy very often means results, the like of which cannot be obtained in any other manner. Such patients are amazed at their progress, their friends see changes in their features and their "view of life" that makes for SUCCESS in practice.

Let us not allow the slightest phase of minor thyroid disorder to pass us again; and let us always remember that **if our diagnosis is wrong the treatment will show it!**

Next month: "The More Serious, Organic Thyroid Diseases." Just as helpful!

*My routine in most cases of functional dysmenorrhea is a modification of a method suggested by Prof. Dalche, of Paris. It consists of administering $\frac{1}{4}$ or $\frac{1}{2}$ a grain of thyroid with 5 grains of lutein (corpus luteum) twice a day for the first ten out of twenty days before the menses are due, and four times a day for the ten days prior to menstruation, i.e. doubling the amount in the last ten days. This is repeated for several months, and, later, the medication is given during a shorter period, first a week in which two doses are given daily, and four doses daily for the week before the menses, and still later three days during which the two doses are taken and four doses for the three days before the expected flow.

INDICATIONS FOR GASTROENTOSTOMY FROM A MEDICAL POINT OF VIEW.*

BY ROBERT POLLOCK, M.D., SAN DIEGO, CAL.

From the standpoint of the internist the indications for the use of any remedy are determined by a study of its physiological action and therapeutic effects. This rule he applies to operations as well as to other remedial measures. What then are the therapeutical effects of gastroenterostomy? They seem to be well expressed by Haeberlin (1) who says, "The modern gastroenterostomy aims to correct stomach errors, chemically, physiologically and anatomically." This is indeed comprehensive and is only saved from vagueness by a close study of the article in which he makes this statement.

It is but fair in considering this remedial measure to discuss only the most finished product available. Statistics seem to point to the posterior, short-loop gastro-jejunosomy as the operation of choice in most cases made use of by the majority of operators.

Mechanically this operation it is claimed obtains sufficient drainage to overcome pyloric stenosis and restore the stomach to its normal size and position. Furthermore, it physiologically reestablishes the stomach's function; both secretion and emptying time becoming more normal. This aids the bowel to fulfil its physiological function without undue embarrassment. Anatomically the most that is claimed for the finished operation is that it preserves the normal anatomical relations of the parts. I am not aware that surgical enthusiasm has claimed to improve upon these; and the controversies relative to the differences in type and technic of gastroenterostomies would lead us to believe that the normal relations of the parts are not always preserved. This impression is further

strengthened by treating the after-results of some gastroenterostomies.

After all is not the internist in the best position to judge of the success or failure of any operation on cases that he refers to the surgeon?

Taking the therapeutic effects above outlined as fairly representing the value of the modern gastroenterostomy in good hands, let us see wherein this remedy is indicated, observe the results obtained from it and compare them with those obtained by other means.

Pyloric stenosis so persistent as to markedly interfere with the emptying power of the stomach, thus allowing food retention with secondary dilatation, would seem to be a clear indication for this operation and undoubtedly in most cases improvement both mechanical and physiological follows its use. However these results are daily being obtained by non-surgical means.

Pylorospasm without doubt is at times established as a result of highly acid gastric secretion, without ulcer or other organic lesion being present. These cases respond promptly to well directed dietetic and medicinal measures. Many of these cases are diagnosed as ulcer and help to swell the number of operative cases of ulcer where no ulcer is found.

About a year ago W. J. Mayo (2) made the statement that: "The most common cause of failure to cure gastric and duodenal ulcers by operation is that the patient did not have the ulcer but did have the operation." Later in the same article he adds: "There can be no doubt that unnecessary gastroenterostomies are being made."

Where pylorospasm with retention and dilatation is caused by ulcer impinging

(1.) Gastroenterostomy. J. B. Haeberlin. N. Y. Med. J., Dec. 4, 1915.

(2.) Wm. J. Mayo in *The Clinics of Jno. B. Murphy*. June, 1915, p. 459.

*Read before the Southern California Medical Society at Pomona, May, 1916.

upon or adjacent to the pylorus, there is room for argument as to the best method of handling each individual case. Many such cases are satisfactorily relieved by a systematic course of rest and diet in accordance with Sippy's elaborate method (3). Undoubtedly some of these so-called cures relapse from various causes; but on the other hand gastroenterostomy has been known to furnish only temporary relief. I feel that in these cases of undoubted ulcer of long standing, the decision should be put squarely up to the patient coupled with our individual advice. Sometimes he will decide in favor of operation rather than submit to the restrictions of medical treatment which he may have previously tried. The feeling may be entertained by him that the surgical route is shorter and more radical. In this he is occasionally disappointed as illustrated by a case under my care at the present time, who with the best of surgical skill gained about a year of freedom from distress following a gastroenterostomy. Two years after this operation an ulcer in the first portion of the duodenum was excised and a pylorotomy performed. Since this second operation, five years ago he has never enjoyed more than six or eight weeks freedom from pain at one time: and he was subject for two years to the tortures of a duodenal fistula which finally closed. His recent distress which has been entirely controlled by modified Sippy treatment is probably due to a stitch ulcer in the jejunum.

Incidentally jejunal ulcer when found is practically always a sequel to a previous gastroenterostomy. Many of these ulcers of long standing are best treated by surgery; but unless otherwise demanded by the patient, they should first be given the benefit of a vigorous course of medical treatment. This will generally result in at least placing the patient in better condition for operation.

There is no class of cases where the co-operation of surgeon and internist can work greater benefit to the patient.

While stomach ulcers that in no way interfere with the emptying power of the organ may be advantageously treated by gastroenterostomy, they will rarely be so treated if given a thorough course of intelligent medical treatment first. By whichever method treated the results are undoubtedly due to the reduction of the acidity of the gastric juice to which the ulcer is exposed.

The trend of surgical opinion is to class an ever increasing percentage of gastric cancers as occurring on the sites of ulcers. Altho statistics are not very definite on this point it is probable that after gastroenterostomy very few stomach ulcers take on malignancy. This is probably equally true of non-operated stomachs where the hyperacidity of the gastric juice is kept well neutralized. There is obvious difficulty in obtaining adequate statistics on such points.

Distinct suspicion of early malignancy in the pyloric region as suggested by fluoroscopic findings and other evidence must be considered an indication for prompt gastroenterostomy as an aid to diagnosis and prognosis as well as a preliminary step to a possible resection. Here the chief function of the internist is to help in furnishing an early diagnosis and no price is too high to place upon such a service.

Aside from malignancy, in certain purely surgical conditions such as abnormal stomach contour due to cicatricial contractions from trauma, ulcer or extraneous inflammation, a gastroenterostomy may with advantage be included as part of the surgical treatment.

According to Patterson (4) apart from organic lesions the only excuse for a gastroenterostomy is continued hemorrhage from the stomach.

(3.) Gastric and Duodenal Ulcer. Medical cure by an efficient removal of Gastric Juice Corrosion. J. of A. M. A., May 15, 1915, p. 1625.

(4.) Paterson, H. J.: The operation of gastrojejunostomy and the principles which should determine its use. S. G. O. 1914, vol. 18, page 423.

All peptic ulcers wherever found should be first given a trial on medical treatment except those that are perforating and those accompanied by repeated hemorrhages sufficient to deplete the blood and lower the circulation.

While gastroenterostomy is sometimes advocated to relieve atony of the stomach musculature expressed by ptosis or moderate dilatation without pyloric obstruction, these conditions are so obviously dependent upon a relaxed condition of the nervo-muscular mechanism that the more logical treatment would seem to lie in efforts to build up the system by dietetic and hygienic means with the use of temporary abdominal support externally and increase of intra-abdominal pressure internally.

When used in accordance with clear indications and by skilled hands the modern operation of gastroenterostomy has a very low mortality and is followed by few disappointments. Through steadily improving technic the failures from this remedial measure are growing less and less common. We still however occasionally meet a "vicious circle" which has resisted operation after operation; while the jejunal peptic ulcer and the ulcer from irritation from non-absorbable sutures have become well-defined possibilities. According to Bryan (5) jejunal ulcer occurs in 1.5 per cent of all gastroenterostomies. Contractions and deformities about the stoma must also be considered.

While the detailed discussion of these shortcomings of the operation is beyond the scope of this paper it must be borne in mind that the main results of the operation, the improved motor and secretory functioning of the stomach, may take weeks, sometimes many months, before they reach the degree of efficiency desired. During this period the patient may pass through many phases of discomfort and functional disturbance of stomach, bowel and

nervous system. These require more or less attention, and we must be careful to combat the impression that the patient becomes of little interest to his doctors after his operation.

In conclusion I would enter a plea for greater co-operation between internist and surgeon where their duties may so obviously overlap. The layman is being steadily educated in a belief in the efficiency of team work in medicine. It is gratifying to him to observe that his internist evinces a lively interest in the treatment preparatory to an operation he has advised: that he apparently is conversant with the details of the operation and intelligently discusses with the surgeons the means to be used to safeguard him, the patient, against undue shock and suffering: and to find after his operation that they are still working together in endeavors to replace him in his accustomed field of work with restored energy and usefulness. The surgeon meanwhile has lost none of his luster and may have acquired some knowledge of the individual patient's personality and habits that are invaluable at such times.

The medical literature of this year shows a great diminution in the number of important articles on surgical topics from the European countries now at war, except the articles on military or war types of surgery, and these even do not show an epoch-making discovery or advance over previous methods. It seems to be fairly well accepted that hypochlorite of calcium with boric acid is one of the best wound disinfectants. It is taking precedence, in practical application, over the older and more toxic antiseptics or disinfectants; this is particularly true in war surgery. Still no adequate means has so far been advanced for a uniform successful disinfection of septic wounds. There is a great and promising field for experimental work in gas gangrene prophylaxis and treatment. Who will avail himself of this golden opportunity?

(5.) Ulcer of the Jejunum. Robert C. Bryan. S. G. O., March, 1916.

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EDITORIAL

DR. ZINKE.

Dr. E. Gustav Zinke, formerly President and now Secretary of the American Association of Obstetricians and Gynecologists and for twenty years Professor of Obstetrics in the Medical College of Ohio (University of Cincinnati) was given a testimonial dinner June 19th, 1916, and presented with a loving cup by his professional brethren at a gathering of 125 representative men in Cincinnati. Addresses were delivered by Dr. Charles Bonifield, toastmaster, Dr. Dabney, president of the University of Cincinnati, Dr. C. R. Holmes, who has fathered the development and construction of the new Cincinnati Hospital, Dr. William Gillespie, Dr. Pantzer of Indianapolis, the present President of the American Association of Obstetricians and Gynecologists, Dr. Sutton of Zanesville, Dr. Yates of Detroit, and two former mayors of Cincinnati, Dr. Louis Schwab and Judge Spiegel. Few men are so worthy of such honor. Dr. Zinke

came to this country when a young man, fresh from the Prussian navy, with limited education and no knowledge of the English language, and with few funds or friends. By industry, close application to work and study, strict honesty in purpose and dealings, he acquired a knowledge of the English language and of Medicine and Surgery far above the average, became a recognized leader in the specialty of Obstetrics, and has secured and maintained the love and admiration of his professional brethren as evidenced by this testimonial dinner. What Americans some Germans become! But the step from the boy from the Prussian navy to the Professor of Obstetrics in the Medical College of Ohio and President of the American Association of Obstetricians and Gynecologists, may not be lightly taken. Though known so well for his industry and honesty, Dr. Zinke will long be remembered for the very practical interest he took in the welfare of the

poor, in the establishment of the Outdoor Obstetrical Clinic and the development of the German Hospital. We may mention a dictum characteristic of the man: "The rich should pay what our services are worth, the poor may pay what they can, and the destitute we deem it a pleasure to serve without price!" Many a poor family has had a frugal meal substituted by a full turkey dinner upon special occasions, such as the holidays, through the generosity of Dr. Zinke. Not infrequently he would demonstrate both his charity and his confidence in therapy by paying for the remedies used in some poverty stricken family for the alleviation of suffering or the prolongation of life. And many a young physician has been helped in his professional career by this far-sighted and truly sympathetic physician. Do you wonder that he was honored by those who knew him best?

So here is to Dr. Zinke! Long may he live and remain active in his chosen profession.

MOSQUITOES IN TREES

The report of the Department of Health of the Panama Canal for April, 1916, says: "During the month the work of cementing tree cavities was undertaken, as this has been recognized as an important antimosquito measure, but had not been undertaken before in Panama City.

"In the city 1,611 trees were treated, plugging such cavities as might become 'containers' on account of holding water. A cement and sand mixture of 1-4 was used to close the cavities. Where large holes were found pieces of rock were used to fill in, reducing amount of cement needed. Count was kept on about 1,000 trees to determine the number of cavities per tree which during the rainy season would act as water containers with consequent mosquito breeding. An average of 2.55 holes per tree was found, and using this figure for total number of trees treated, we find

that 4,108 possible containers were eliminated. The large trees presented the greater number of cavities, naturally, and decayed places where limbs had been broken off, and in the angles formed by branching were to be found the most frequent sites. As many as 22 cavities were found in one tree requiring filling.

"It is interesting to report that quite a number of the cavities found, even at this season of very little rain, contained mosquito larvae, and larva from several of these were identified later as stegomyia. Stegomyia were only found, however, in trees quite close to houses."

While this work refers to sanitation chiefly, yet it is really tree surgery too. Many fine trees in our yards and on our streets would have many years more of healthy life if the above described operation were performed.

STATE PHARMACEUTICAL ASSOCIATION

The California State Pharmaceutical Association convened in Los Angeles June 14-15, 1916. Throughout the session practical subjects were dealt with in a business-like way. The business of pharmacy seemed to take precedence over the profession of pharmacy. If we were to offer a criticism it would be that in the practice of medicine and surgery, we are too prone to permit our professional interest to overshadow or obscure our common sense business-like conduct of our practice. Indeed, there are many things we might learn from our fellow practitioners of the healing art, the pharmacists—and the nurses.

MAY PRACTITIONER

If you have a copy of the May, 1916, Southern California Practitioner, that you do not need for your files, your courtesy will be appreciated if you will send it to Mrs. Elbert Wing, Wianno, Mass. We are obliged to make this request because our supply is entirely exhausted, save the copy that we must retain for our office file.

EDITORIAL NOTES

Dr. George H. Kress is hiking in the Sierras.

Dr. William V. Whitmore of Tucson has just completed his first year as president of the University Club.

Dr. Eugene Talmage and Miss Edith A. James were married in the Church of the Redeemer, Los Angeles, February ninth.

Dr. Carl Wheeler Rand has opened offices in the Brockman Building, Los Angeles.

Drs. C. C. Browning and E. M. Brown have removed their offices to the Merritt Building (The Marble Palace) 8th and Broadway, Los Angeles.

Want to buy a second hand Vulcan coil, any type. Don't care for the accessories. State price, style and number. X-Y-X, Southern California Practitioner.

Dr. Granville MacGowan with his retinue of assistants has taken offices in the Brackett Building, 527 West Seventh Street opposite the Brockman Building.

The Journal of Delinquency is a most commendable publication issued bi-monthly by the Whittier State School Department of Research, Whittier, California. The subscription price is \$1.25 per annum. It brings much of especial value to the alienist.

The medical and dental professions of San Diego have been enjoying, during the past few months, some very interesting scientific discussions on topics having a common interest. This commingling of wits and sociability of these two professions ought to be productive of much benefit to each.

Dr. Clarence Moore and Dr. Rea Smith bought an automobile (yes, it was a Ford) in Salt Lake City and with

Dr. Judd of the Mayo's and Dr. Percy of Illinois they motored up to the Flat Rock Fishing Club for a couple weeks "fishing". We refuse to publish any of their stories.

The Fellows Medical Manufacturing Company of 26 Christopher Street, New York, are distributing an interesting brochure, depicting important ocular conditions, that is adapted to the needs of the general practitioner and optometrist. Write them, if you have not received your copy.

Dr. Anders Peterson and Mr. Mendel Silverberg rigged up an automobile with a most complete camping outfit and went by way of Yosemite to join the Los Angeles and Mayo campers of Flat Rock Fishing Club fame. From there they will go through the Yellowstone to Rochester, Minnesota, where Dr. Peterson will specialize in genito-urinary work.

Dr. W. J. Cross and wife, of Melbourne, Australia, were recent arrivals at the Hotel Alexandria. Dr. Cross has back-slidden, inasmuch as he has retired from the active practice of medicine to look after his mining interests and enjoy life. They declare that Los Angeles reminds them of their home in Australia. We have much the same climate and vegetation. That reminds us: Where did the blue gum tree originate?

Dr. Lacy, formerly second assistant, has been promoted to first assistant superintendent of the Los Angeles County Hospital. The position was vacated through Dr. Peterson resigning to take up genito-urinary work in the Mayo camp. Dr. P. K. Kelforth is the new second assistant. The positions of first and second assistant and four positions as house physicians are open to the internes through competitive examination under civil service regime.

BOOK REVIEWS

INTERNATIONAL MEDICAL ANNUAL. A Year Book of Treatment and Practitioner's Index. 1916. Thirty-Fourth Year. New York; William Wood and Company. Price, \$4.00 Net.

The past year has not only been remarkable for the enormous number of injured men our profession has had to deal with, but also for the expert and detailed investigations which have been made on every point tending to the protection of the soldier from the adverse conditions to which he is exposed. This issue of the Annual presents the results of this large experience and fruitful investigation in a form convenient for rapid reference. A special section is devoted to Naval and Military Surgery. This is one of the most interesting and instructive volumes of the entire series. If you think you are keeping up with the times in your profession, try to give the definition of the following words taken from the glossary of the newer terms: acapnia, anisocytosis, diadokokinesis, hyperpiesis, microtia, phosphatids, polynucleosis.

DISEASES OF THE SKIN. By Richard L. Sutton, M.D., Professor of Diseases of the Skin, University of Kansas School of Medicine; Former Chairman of the Dermatological Section of the American Medical Association; Member American Dermatological Association; Assistant Surgeon, United States Navy, Retired; Dermatologist to the Christian Church Hospital. With Six Hundred and Ninety-three Illustrations, and Eight Colored Plates. St. Louis. C. V. Mosby Company. 1916.

This is a very attractive volume of 916 pages, is well written, copiously illustrated, and bears evidence of an enormous amount of work in literary research, clinical investigation, and, possibly most important, in the elaboration and lucid presentation of the subject from the standpoint of diagnosis. The classification adopted is based on Crocker's modification of the well known scheme of Hebra, that has done so much to clarify the subject and simplify the study of the diseases of the skin. We are glad to give space here to the following, showing the regional distri-

bution of the commoner diseases of the skin:—

Scalp.—Seborrheic dermatitis, eczema psoriasis vulgaris, ringworm (children only), lupus erythematosus, pediculosis capitis, infectious eczematoid dermatitis.

Alopecia.—Alopecia pityroides, alopecia areata, secondary syphilis, folliculitis decalvans.

Unclassified.—Gumma, carcinoma cutis, verruca, sebaceous cysts.

Face.—Freckles, chloasma, leucoderma, eczema, dermatitis seborrhea, dermatitis venanata, impetigo contagiosa, erysipelas, acne rosacea, secondary syphilis, lupus erythematosus, ringworm, erythema multiforme, lupus vulgaris, seborrheic keratosis, carcinoma cutis, blastomycetic dermatitis, herpes simplex, herpes zoster, milium, molluscum contagiosum, adenoma sebaceum, xanthoma palpebrarum (eyelids).

Bearded Region.—Impetigo contagiosa, eczema, sycosis vulgaris, tinea barbae, alopecia areata.

Lips.—Herpes simplex, carcinoma cutis, chancre, cheilitis exfoliativa, cheilitis glandularis apostematosa, Fordyce's disease, urticaria gigans.

Tongue.—Leucoplakia, chancre, gumma, carcinoma, transitory benign plaques.

Chest and Shoulders.—Seborrhea, acne vulgaris, secondary and tertiary syphilides, tinea versicolor, seborrheic keratoses, scabies, psoriasis, pediculosis corporis, drug eruptions, the acute exanthemata, ichthyosis.

Breasts.—Eczema, infectious eczematoid dermatitis, purpura, seborrheic dermatitis, pityriasis rosea, urticaria, herpes zoster, syphilis, psoriasis, ichthyosis.

Hands and Feet.—Leucoderma, dermatitis venanata, eczema, scabies, hyperhidrosis, pompholyx, palmar and plantar keratoses, infectious eczematoid dermatitis, erythema multiforme, syphilis, dermatitis repens.

Forearms and Legs.—Infectious eczematoid dermatitis, eczema, ecthyma, urticaria, lichen planus, psoriasis (extensor surfaces of elbows and knees) ichthyosis, erythema multiforme, erythema nodosum, leucoderma, purpura, keratosis pilaris, gummata.

Genital Region.—Pruritis, scabies, seborrheic dermatitis, herpes simplex, chancre, chancroid, lichen planus, carcinoma, dermatitis, venenata.

Anal Region.—Pruritis, eczema, condyloma, fissures.

Crural and Axillary Regions.—Ringworm, seborrheic dermatitis, erythema intertrigo, eczema, scabies (in axillary folds), erythrasma, furunculosis and infectious eczematoid dermatitis.

INTERNATIONAL CLINICS. Edited by H. R. M. Landis, M.D., Philadelphia, U. S. A. Volume 11. Twenty-sixth Series, 1916. Philadelphia and London. J. B. Lippincott Company.

One of the most valuable and interesting of the many important articles in this number is on Milk and Dairy Inspection in Cincinnati, by J. H. Landis, M.D., Health Officer of Cincinnati and Professor of Hygiene in the Medical Department of the University of Cincinnati. We cannot resist reproducing a few quotations.

"The overwhelming majority of people judge of the quality of milk by the cream line, with never a thought given to the sediment that may, and too frequently does, cover the bottom of the bottle."

"'Political expedience' should be listed as the predisposing cause of death on thousands of death certificates which are filed away with typhoid fever, diphtheria, scarlet fever, septic sore throat, or gastro-enteritis as the sole clew to what condition was responsible for the tragedy."

"Opposition to this regulation was pronounced at first, but at the present time if any one desired to start a riot backed exclusively by the milk industry the one sure way to do it would be to try to eliminate pasteurization in this city." "At present every drop of milk on the Cincinnati market, with the

exception of that produced under the supervision of the Milk Commission of the Academy of Medicine, is pasteurized."

"The reduction in the general death-rate of a municipality brought about by the purification of its milk supply, is practically the same as that caused by its change from a polluted to a pure water supply."

Landis concludes by noting the following points:—

First.—A maximum of efficiency in milk inspection can only be secured through officials who are entirely free from political control.

Second.—Freedom from political control can only be obtained through a non-political board of health, composed of men selected because of their fitness, and not because they have rendered valuable service to some political party.

Third.—An expert veterinarian with a comprehensive knowledge of every angle of the milk industry is essential to success. In addition, he must have the build of a prize-fighter and the heart of a gladiator, for he will need both in his daily work. Having them, the necessity for using them will be practically nil.

Fourth.—Reforms in methods are not secured all at once. A multitude of orders has been the insurmountable obstacle leading to the failure of many earnest men who have entered this field of work and had their efforts nullified by the great mass of opposition aroused. Get one thing done at a time.

Fifth.—The education of the public must keep pace with that of the dairyman. "Show your goods" to business organizations, civic clubs, mothers' clubs, women's clubs, secret societies, church and school audiences, and make every newspaper man an assistant health officer without pay. The press of a city can make or break any man in public service. It is my belief, based on over six years of public health work, that a department entirely free from party

domination can absolutely rely on the backing of a united press.

Sixth.—Do not use too much time using moral suasion. Moral suasion speaks in a whisper; a successful police court prosecution shrieks from the rooftops and from the printed page of every newspaper.

To these statements we would add, that an influential dairy, such as the French Brothers that did much to inaugurate the Cincinnati reform, or the Arden Dairy, that has initiated much of the good work among the dairymen in the region of Los Angeles, may render a most important sanitary service by showing that strict cleanliness pays in the dairy business. Possibly the time will come when those we regard as the laity will not regard it as esthetic to consume milk or meat from sick cows. Many a dairyman has been surprised to find how many of his cows were tubercular, when properly examined by a competent veterinarian.

PROGRESSIVE MEDICINE. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D. Professor of Therapeutics, Materia Medica and Diagnosis in the Jefferson Medical College, Philadelphia; Physician to the Jefferson Medical College Hospital; One Time Clinical Professor of Diseases of Children in the University of Pennsylvania; Member of the Association of American Physicians. Assisted by Leighton F. Appleman, M.D. Instructor in Therapeutics, Jefferson Medical College, Philadelphia; Ophthalmologist to the Frederick Douglass Memorial Hospital and to the Burd School; Instructor in Ophthalmology, Philadelphia Polyclinic Hospital and College for Graduates in Medicine. Volume 11. June 1916. Hernia—Surgery of the Abdomen, Exclusive of Hernia—Gynecology—Diseases of the Blood. Diathetic and Metabolic Diseases. Diseases of the Spleen, Thyroid Gland, Nutrition, and the Lymphatic System—Ophthalmology. Lea and Febiger. Philadelphia and New York. 1916.

This issue contains an excellent summary and review of the recent prolific literature on gunshot sounds of the abdomen, in war. No new methods of treatment have been evolved. The entire question has revolved around indications for operative interference. At first, when the armies were still actively moving, it took nearly a week before the wounded reached hospitals equipped with adequate

surgical facilities. At this time the advocates of the conservative (non-operative) treatment held the upper hand—the mortality from operations was distinctly higher than from non-operative measures (i. e., morphine, Fowler's position, starvation, administration of water subcutaneously or by proctoclysis). Later, when the great forces settled down to practically fixed positions in trenches, transportation improved and the wounded reached the surgeons in a much shorter time: now the advocates of immediate operation came into their own. The consensus of opinion at present indicates that every penetrating wound of the abdomen should be operated on within the first twelve hours, provided the patient's condition permits. Shock is no contra-indication. In short, the indications are identical with those which hold for gunshot wounds of the abdomen, encountered in civil life. The knowledge gained through autopsy and operative experience in the present war indicates that those not dying from hemorrhage upon the field of battle, die from peritonitis upon the second, third, or fourth day (Toefer). The patients with abdominal wounds who reach a base hospital alive, at the end of a week represent an extremely small fraction of the total number who have sustained abdominal wounds upon the battlefield. Among this relatively small group of cases are:

1. Those diagnosed as penetrating injuries of the abdomen, but actually without penetration of the hollow intra-abdominal viscera, i. e., there has been a tangential injury of the abdominal wall, or else a very rare but repeatedly observed happening, the projectile has traversed the abdomen without injuring stomach or intestines.

2. Wounds of the stomach, much more given to spontaneous healing than those lower in the alimentary canal.

3. Those in which the inflammatory process had become localized. Naturally, under such circumstances, the conserva-

tive treatment gave relatively good results, and so the erroneous impression was gained, that wounds of the abdomen sustained in war, gave a lower mortality than in civil life. To be of value, statistics regarding abdominal wounds must include: The percentage of those dying upon the battlefield, the percentage of wounded dying near the front, and the percentage of those dying long after injury, i. e., those invalidated home. The rule is not to report cases "cured" unless they are seen on the fifteenth day after operation and are doing perfectly well at that time. Individual surgeons have given their personal experiences, but they were not in a position to obtain the above mentioned data, hence they were led to draw erroneous conclusions. It is to be noted that most medical observers in previous wars of recent date, were stationed at base hospitals far from the front.

DISEASES OF THE DIGESTIVE TRACT AND THEIR TREATMENT. By A. Everett Austin, A.M., M.D. Former Professor of Physiological Chemistry at Tufts College, University of Virginia, and University of Texas; Present Assistant Professor of Clinical Medicine, in Charge of Dietetics and Gastrointestinal Diseases, Tufts College; Member of American Gastroenterological Association and American Society of Biological Chemists; Physician to Mt. Sinai Hospital and Berkeley Infirmary, and Assistant to Boston Dispensary; Author of "Manual of Clinical Chemistry." With Eighty-five Illustrations, Including Ten Color Plates. St. Louis. C. V. Mosby Company. 1916.

The first paragraph of the Preface opens as follows: "Of the making of books there is no end," was the dictum of Milton, and it is as true now as when written." Which would seem to indicate that the writer is quite a student and admirer of Milton, who possibly had read Ecclesiastes XII, 12: "And further, by these, my son, be admonished: of making many books there is no end; and much study is a weariness of the flesh." We were so charmed by the author's artistic literary style that we failed to note and attempt to verify any further quotations. It is a modern, up-to-date presentation of the subject by a competent observer. There are

many very attractive reproductions of radiographs of the gastro-intestinal tract. If we were to criticise these, we would suggest that the "crook form," depicted as a normal stomach in figure three, with the longer part of the crook extending from the diaphragm to the pelvic cavity, and the duodenum about midway between the pelvis and the umbilicus, is a type that we have rather frequently seen but never regarded as normal for the very good reason that we never found it in a healthy person. Those we observed were neurasthenic and of the emaciated ptosis type. In fact, it is difficult to picture the stomach as a normal pelvic organ, though in the literature we find some remarkable anomalies noted in which we are assured there were no symptoms. It is possible that in such cases symptoms were not noted because they were not observed rather than because they did not exist. However, this is a volume that you will enjoy reading, and that it will be a pleasure to have for reference. It seems impossible for a reviewer to depict in proper proportion the many helpful features and the true value of such an important treatise. The author was first a physiological chemist, and approaching the subject of diseases of the gastro-intestinal tract from the standpoint of physiological chemistry is advantageous.

SKIN CANCER. By Henry H. Hazen, A.B., M.D. Professor of Dermatology in the Medical Department of Georgetown University; Professor of Dermatology in the Medical Department of Howard University; Sometime Assistant in Dermatology in the Johns Hopkins University; Member of the American Dermatological Association. With Ninety-seven Text Illustrations, and One Colored Frontispiece. St. Louis. C. V. Mosby Company. 1916.

At the present time the profession is rapidly awakening to the importance of cancer. When one considers that epithelial growths of the skin, both benign and malignant, are so common, that they are usually so easily diagnosed, that the tissue from them is readily obtainable for histological study, and that most of them are so amenable to proper treatment, it is surprising how much ignorance

prevails concerning them. In this small volume the author gives evidence of considerable literary research. If we were to offer a criticism it would be that he has not invariably been altogether fortunate in his selections, a fault that will probably be corrected in subsequent editions.

THE CLINICS OF JOHN B. MURPHY, M.D., at Mercy Hospital, Chicago. Volume III., Number III. (June 1916). Octavo of 176 pages, 42 illustrations. Philadelphia and London: W. B. Saunders Company, 1916. Price per year. Paper, \$8.00; Cloth, \$12.00.

Murphy's Clinics for June opens with an address by Dr. R. C. Coffey, of Portland, Oregon, in which the "two sitting" operation is advocated for gastroen-

terostomy and resection of the pylorus or stomach for cancer, and also in the operation for cancer of the rectum. He believes the mortality is reduced fully one-half by the two-stage operation for cancer in these regions.

PRACTICAL MEDICINE SERIES. Comprising Ten Volumes on the Year's Progress in Medicine and Surgery. Under the General Editorial Charge of Charles L. Mix, A.M., M.D., Professor of Physical Diagnosis in the Northwestern University Medical School. Volume 11. General Surgery. Edited by John B. Murphy, A.M., M.D., L.L.D., F.R.C.S. England (Hon.), F.A.C.S. Professor of Surgery in the Northwestern University; Attending Surgeon and Chief of Staff of Mercy Hospital and Columbus Hospital; Consulting Surgeon to Cook County Hospital and Alexian Brothers Hospital, Chicago. Series 1916. Chicago. The Year Book Publishers. 327 S. LaSalle Street.

MISCELLANEOUS

DISEASES OF THE CIRCULATORY SYSTEM.

The Etiology of the Diseases of the Circulatory System, was chosen for the Shattuck Lecture delivered by Theodore C. Janeway, M.D., of Baltimore, before the Massachusetts Medical Society, June 6, 1916. The following practical conclusions seem warranted:—

I. Reduction of the mortality from circulatory diseases is attainable.

II. The measures now possible, which will yield definite results, are, in order of their importance and feasibility:

1. The diminution of syphilitic infection and the early diagnosis and intensive treatment of primary syphilis.

2. The further reduction in preventable infectious diseases, especially diphtheria, scarlet fever and typhoid fever.

3. The education of the public to consider "rheumatism" a serious disease, particularly in childhood, and to seek competent medical advice at once; and the education of the medical profession to treat even the mildest rheumatic fever in bed with large doses of salicylates from the earliest possible moment.

4. The provision of convalescent hospitals for the necessarily protracted after-care of cases of acute inflammatory

disease of the heart and of patients recovering from myocardial insufficiency.

5. The development of suitable employments for cardiac patients, and of the social and economic machinery necessary to placing them in such employments.

6. General hygienic measures, including the promotion of temperance.

7. The medical examination of the supposedly healthy at stated intervals.

III. No large reduction of the mortality from circulatory diseases is likely until two groups of problems have been solved:

1. The ultimate causes of hypertension and of chronic nephritis.

2. The infectious agent of rheumatic fever and its portal of entry.

IV. The solution of these problems, if of such a nature as to lead to practical measures, with the elimination of syphilis, would almost abolish disease of the circulatory system, except in the aged.

The need of the moment, therefore, is for more knowledge; not more knowledge of the dangers of circulatory diseases for the public, which means propaganda, but more knowledge of their causes for the physician, which means ceaseless investigation.

INTEROL.

The world is full of fallacies—it is fed upon half truths. It drinks in sophistry and then wonder is expressed that the millenium is so long deferred. Take, for instance, the unfortunate use of the terms “expensive” and “high-priced” or of “costly” and “cheap.”

Price—be it high or low, is what one pays.

It has nothing to do with what is received.

Quality, on the other hand, is what one gets—or fails to get. Service ditto.

A useless, or inferior article or service, even when bought for a low price, is expensive and costly!

On the other hand, the better or higher the Quality or the Service that is obtainable, the higher the price—which is a great natural law. Hence, high-priced should and usually does mean, high quality or service.

In fact, a moment's reflection will show that the impression created in the mind of a person of average intelligence, by the word “cheap” applied to a person or a thing, suggests inferiority.

A cheap person or thing is apt to prove the most expensive. A high-priced person or thing usually turns out to be the most economical.

And it is a most important fact that this applies with especial force to therapeutic agents of any kind intended for use by the physician, and with fulminant emphasis to drugs or agents that have to be put into the human body.

The physician who hesitates or is influenced by “high price,” provided he knows the reputation and standing of the parties marketing the product, is false to his obligation, to himself and to his patient.

K-Y LUBRICANT.

Friction physiologically considered is a thing to be avoided. Its proper antidote is lubrication. The correct form of lubrication calls for slipperiness which is not supplied by grease or oil. Furthermore, grease or oil is unpleasant

to use and it leaves behind stains or soiled places on the patient's linen, etc.

Instruments of penetration—such as the sound, catheter, speculum, scope or the examining finger, must be lubricated and so perfectly lubricated as to slip easily. To pass such an instrument deftly, quickly, with a minimum of pain or discomfort to the patient, requires perfect lubrication, which in turn, enhances the manual dexterity and deftness of the operator. Patients are growing to be increasingly critical. They note their physician's attention to the “little things” and judge accordingly. Hence anything that will add to his skill or deftness must appeal to the doctor and for that reason he must be interested in K-Y Lubricating Jelly—Friction's Antidote.

This preparation is slippery but not sticky. It is greaseless. It is water-soluble. It is transparent. It is non-irritating. It is convenient to use and economical—properties which will recommend it to the discriminating doctor who has his patient's best interests, as well as his own, at heart. K-Y Lubricating Jelly is also a valuable emollient and protective agent, in burns, scalds, bed sores, chafes, dermatitis, urticaria, hives, etc.

It relieves pruritus in the majority of instances and is exceedingly useful as a soothing and protecting application to the skin of children suffering from scarlet fever, measles, chicken pox, etc.

K-Y Lubricating Jelly also keeps the surgeons' hands smooth, prevents bichloride rash and “improves the feel.”



SOUTHERN CALIFORNIA PRACTITIONER.

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THE DIAGNOSIS OF THE INTERNAL SECRETORY DISORDERS.

BY HENRY R. HARROWER, M.D., F.R.S.M., (LOND.), LOS ANGELES, CAL.

IV.

The More Serious Organic Thyroid Diseases.

Like most organs of the body, the thyroid gland may be the subject of both hypertrophic and degenerative diseases. These exert a well marked influence upon the physiological activities of the organism, not merely due to the effects of the disease *per se*, but more particularly because of the wide-spread effects of the resulting dys-hormonism.

Thyroid Tumors—Goiter.

The usual organic disorders such as carcinoma and sarcoma are somewhat rarely found in the thyroid, though this gland is considerably more frequently the seat of a tumor growth known as an adenoma, which may or may not become malignant. It should be understood that these tumors may be present with no decided change in the internal secretory capacity of the gland, while on the other hand either a reduced or an increased functional activity may accompany the evolution of the new growth.

Quite the most common tumors of the thyroid gland are the well known goiters, the incidence and frequency of which is well recognized, and the symptoms of which may vary from the seriously toxic exophthalmic form of goiter to the practically inactive hyperplastic condition. It is very necessary to be able to differentiate between the various forms of thyroid enlargement, since both prognosis and therapeutics depend altogether upon the variety of pathological change that may be present. It must be remembered that at the beginning of puberty and during pregnancy, there is a normal functional increase in the work of the thyroid and frequently this is accompanied by a slight enlargement of the gland which has no pathological significance. These physiological enlargements should be watched, however, as the change from normal to abnormal is insidious and, unfortunately, quite common.

The so-called "simple goiter" may be of three distinct types: (a) Paren-

chymatous (increased proliferation of the thyroid structure and follicles) in which case the gland is moderately firm to the touch and regular; (b) Colloid (increased production of the material in the follicles) with a comparatively large and soft tumor; and (c) Cystic (a modification similar to the colloid form in which the follicular contents are fluid) in which there is a distinct fluctuation present.

With these several forms of simple goiter there are often no important general symptoms, although one must expect to find local disturbances depending upon the degree of pressure that may be exerted by the enlarged gland. It can be readily understood that the intrathyroid changes may diminish the secretory powers of the glandular tissue, whilst the hyperplasia causes a considerable increase in the size of the gland. This explains the presence of hypothyroidism in goiter and also the occasional value of thyroid therapy in goiter, for as Falta says: "for the most part there is sufficient parenchyma capable of functioning." When this comparatively healthy portion of the gland is not enough to supply the necessary amount of hormones, the homostimulant action of the thyroid which may be administered, suffices to increase the functional activity of the healthy remainders and thus augment the deficiency with resulting clinical benefit.

The "simple" goiters may and quite frequently do lose their simplicity—the sound secretory portions of the gland may hypertrophy and a condition of hypersecretion supervene—in which event the clinical diagnosis is not usually made by the local examination, but rather by the study of the manifestations of dys-hormonism which accompany the goiter, and which will be referred to shortly.

The well defined and localized goiters are generally called adenomata, and these commonly have a distinctly nodu-

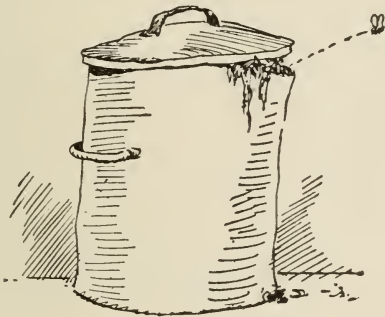
lar feeling. Where there is an accompanying syndrome which includes anemia and cachexia, suspicions of malignancy are warranted. The confirmation of such suspicions is usually made after an operation, although occasionally the presence of metastatic growths is convincing though belated evidence of the malignant character of the tumor.

The thyroid gland may be the subject of an acute infectious process of varying severity. This has been seen to follow an infective process elsewhere in the body, particularly in the tonsils, as well as a number of the acute infectious diseases. Not infrequently it occurs in the primary stage of syphilis. From a diagnostic standpoint the most important findings in acute thyroiditis included the rapid onset and well defined enlargement of the gland with extreme local tenderness, exquisite pain extending up and out to the throat, ears and neck, fever, the results of increased thyroid function—especially *cardiae*, and, in advanced cases, pus formation with fluctuation.

Sclerotic changes may follow an acute inflammatory process and are not uncommonly also seen in tuberculosis, syphilis and alcoholism. The direct result of this condition is likely to be a varying degree of hypothyroidism (discussed in the previous chapter) which even may become a well defined myxedema.

Myxedema.

The organic changes in the thyroid just mentioned are less frequent than those functional-organic changes which differ from the minor thyroid disorders outlined in the previous article only in degree. The well defined and chronic secretory disturbances of the thyroid gland are practically always accompanied by structural changes, insufficiency being associated with sclerosis or atrophy and increased activity with hypertrophy and increased vascular engorgement.



HAVING SPENT THE NIGHT
IN A GARBAGE CAN THAT
SOMEONE HAD NEGLECTED TO
COVER UP

—Los Angeles Herald.

The first of these is myxedema or organic hypothyroidism. We have already seen that this may be of very slight degree with a large series of inconspicuous symptoms. It may be more marked—the *myxédème fruste* of Heretoghe, or, again, it may be so well established that the thyroid aplasia results in a typical myxedema, the symptomatology of which we now may discuss briefly. Incidentally the disorder known as cretinism is really an early myxedema or athyroidia, and save for the well defined developmental disturbances due to the earlier lack of the thyroid hormones, the symptoms are practically the same.

Naturally one would expect to find a similarity between the manifestations of myxedema and the minor form of hypothyroidism, and this is the case, the difference being chiefly in degree. The changes in the skin are most obvious and it is due to their prominence that the disease received its name. They are dependent upon the condition of infiltration or edema (which is not really edema, for the infiltrated products are mucoid rather than fluid, and there is no pitting on pressure) which causes well marked trophic changes in the skin itself, as well as in the dermal appendages. The color of the skin is a buff-pink, sometimes almost grayish. It is said by some to look like alabaster. It is puffy, dry, desquamates easily, and the sweat glands are inactive. The skin is often unusually susceptible to local infections. The hair is dry and brittle and falls out in large quantities. The nails crack easily and are dry and poorly nourished. The teeth are almost invariably in very bad order.

The vital processes as a whole are reduced to a minimum. The temperature is from one to several degrees below normal, metabolism is reduced and with it the elimination of wastes by all channels. Toxemia is, therefore, the rule and this favors a condition of invinci-

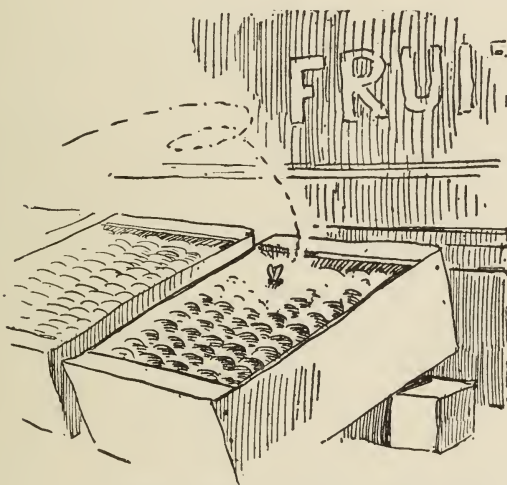
ble constipation which is also usually present. Despite this toxemia the heart action is usually reduced with a slow pulse and a tension often below normal. As a further result of this there is a well marked anemia and especially a hemoglobinemia.

The retrograde changes in the mental powers are very marked, in fact the whole of the nervous system is extremely inactive. The reaction of the body to external stimuli is very poor. Mentality may vary from dullness to complete amentia, and in early cases, loss of memory and inability to concentrate and the general disinclination to use the mental powers, is the rule.

Impotence is the rule in men, and in women either amenorrhea or menorrhagia. (In the first instance the gonads lack the stimuli from the thyroid which are undoubtedly a factor in establishment and maintaining the molimina, while in the latter the infiltration of the myometrium and endometrium coupled with a subtle change in the chemistry of the blood may cause an increased and prolonged menstrual flow.) Atrophy of the genitalia may take place, but is not so marked as in hypophysial disease, of which more later.

Cretinism.

In infantile myxedema or sporadic cretinism, in addition to the findings previously mentioned, there is an almost entirely retarded mentality and physical backwardness and, of course, the sexual development is practically stopped. The face has a broad, puffy, "sloppy" appearance. "saddle nose" is frequent, and the capacity to respond by a smile, a twinkle of the eye, or motions of the facial muscles, is almost entirely lost—but this is mental as suitable tests will show no paralysis present. The bones are abnormally formed, short and stubby. The figure is deformed, the gait awkward, and sometimes walking is impossible. Coordination is poor.



I HAD BREAKFAST OF SOME
FRUIT I FOUND IN FRONT
OF A STORE

—Los Angeles Herald.

The abdomen is soft and prolapsed, the condition known as "pot-belly" being frequent.

The general metabolic inactivity favors the deposit of fat and the condition of thyroid obesity is quite common in cretinism as in the minor hypothyroid insufficiencies.

A word should be added here about endemic cretinism as compared with the "sporadic" form just mentioned. This condition is extremely rare in the United States, but common in Switzerland and Austria. The distinction lies in the heredity, endemic cretins are descended from cretin families and are born in places where cretinism is prevalent. The clinical manifestations are, perhaps, not always so completely typical as in the sporadic form, and occasionally procreation is possible. In addition to the stigmata of cretinism already outlined, umbilical hernia are very common in the endemic form of cretinism. Deafmutism is very often associated with thyroid aplasia. According to Scholz nearly 30% of the endemic cretins seen by him were deaf mutes.

There is another important distinction between these two forms of cretinism—the sporadic form responds wonderfully to thyroid medication, while the endemic form may or may not be benefited by this method of treatment.

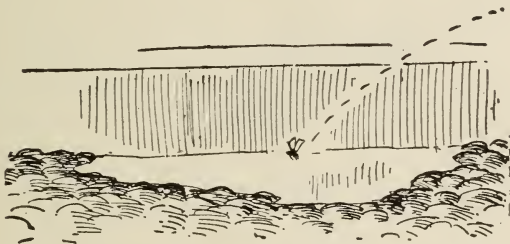
Hyperthyroidism.

The other form of thyroid dyscrasia is thyrotoxicosis or hyperthyroidism, and is the best known and most complex of all the functional thyroid diseases. Here the thyroid gland is unusually active with or without a marked increase in its size. This condition is most commonly called "exophthalmic goiter," though an excessive thyroid secretion may be present without the exophthalmos, and, rarely, the exophthalmos may be present without the goiter. (Parenthetically the use of a physician's name to identify this dis-

ease is confusing. Parry discovered the syndrome first (1786), Flajani described it again later. Graves explained the syndrome intelligently (1835), while v. Basedow (1843) gave a better description and connected the disorder more definitely with its real cause.)

A few words as to the principal causes of this complex disease may facilitate our study of its diagnosis. Three great factors must be taken into consideration: Focal infections; fright and emotional affections and the thyroid instability so well emphasized by Leopold Levi and discussed previously. Fright and excessive emotions are not uncommonly connected with the onset of a severe degree of exophthalmic goiter and Cannon's recent researches into the relation of the emotions to adrenal excitation may be the basis of a satisfactory explanation as to how this is caused. For instance, it is quite possible that the undue stimulation of the adrenals thus brought about may so decidedly push the thyroid pendulum, as to cause it to swing very much more rapidly and widely than is normally the case, while the resulting dyshormonism may prolong the effects for the thyroid itself is just as susceptible to the thyroid hormones in the blood as are any of the other organs of the body.

Toxemia, usually of bacterial origin, is probably the most common cause of this disease, and a careful study very often will reveal some focus of infection in one part of the body or another. Most common among these sources of bacterial poisoning are the tonsils, nasal fossae and adjoining sinuses, teeth and gums (and especially around the roots of the teeth), colon, (especially the angles), gall bladder and pelvic organs; probably in the order mentioned; Undoubtedly there is also a connection between the incidence of hyperthyroidism and the gonads, especially in women, and the frequency of this disease in women, about 10 to 1, and the common



STOPPED FOR A MOMENT
AT A POOL IN THE
GUTTER FOR A DRINK.....

—Los Angeles Herald.

relationship of menstrual disturbances with it, and *vice versa*, are sufficient confirmation of this. That these gonad disorders are usual in individuals with that subtle disorder named "*l'instabilité thyroïdienne*" and that an hereditary defective thyroid substratum favors the onset of dysthyroidism, is well borne out by those who are in the habit of making a thorough anamnesis.

Aside from the two symptoms embodied in the name—*exophthalmos* and *goiter*—symptoms which we need not dilate upon here, the most obvious diagnostic finding is the serious change in the heart action. *Tachycardia* is practically the rule, the pulse ranging from 120 to 180 beats per minute. With this is an extreme degree of nervous irritability, a good part of which, in the estimation of the writer, is due to the functional circulatory changes, although there are cases in which these nervous manifestations have nothing to do with the heart. The cardiac excitability—it is often of a heaving, pounding nature—is responsible for the pulsation not merely of the goiter itself, but of various vessels throughout the body, and this persistent beating in the head, the abdomen and especially the throat and neck is a very uncomfortable symptom. The undue strain on the heart often causes dilatation and even incompetency. Some writers mention the auscultation of a murmur over the goiter.

As might be expected the metabolism is decidedly plus. All the cells are working overtime as a result of the excessive thyroid stimuli and this is doubtless responsible for the hyperthermia which is quite common in the well marked cases of this disease. It also accounts for the loss of weight (despite the not infrequently increased appetite and intake of food), the increased perspiration and, probably, for the sharpened mental activities. In this connection one of the difficult features of hyperthyroidism is the control of the mental status with its disturbances of

concentration in work and its effects upon insomnia. It has been remarked by several writers, and especially by Leonard Williams of London, that among the earliest signs of excessive thyroid action is a tendency to genius, such individuals have great ideas, lean to literature or the arts, take up fads and are far from dull in their studies or their work.

With the decided effects of *myxedema* upon the skin, one would expect some opposite changes in the skin in this opposite condition, and this is the case. The skin is usually thin and delicate, is moist and well nourished by a very good blood supply. The skin reddens under the slightest local or emotional influence and the sweat glands become active on the slightest provocation until the hyperidrosis is more than a nuisance. Occasionally this is one of the earliest symptoms and night sweats of thyroid origin have led the diagnostic scent away from the right trail.

The toxemia, sympathetic irritability and cardio-vascular excitability together form a combination which may produce many and varied symptoms only a few of which need be enumerated, i. e., tremor, twitchings of the eyelids and face, restlessness, insomnia and often a decided neurasthenia. *Myasthenia* with an aggravating fatigue and much discomfort on exertion are usual and to be expected in a disease in which the hormonal balance is so thoroughly disorganized.

The late symptoms of *exophthalmic goiter* include serious heart changes both in the sounds and the rhythm. Heart failure is a common cause of death from this disease. *Dyspnea* and severe *diarrhoea* are also ominous signs when found accompanying other signs of hyperthyroidism.

715 Baker-Detwiler Bldg.

Editor's Note: An opportunity is offered to interested readers to submit clinical questions for answer in an early issue.

The next article will be entitled: "The Adrenal Glands in Health and Disease."



PLAYED WITH A CAT FOR
AWHILE THAT I FOUND
EATING A DECAYED FISH
HEAD.....

—Los Angeles Herald.

PLACENTA PREVIA.

BY D. A. THIEME, M.D., LOS ANGELES, CAL.

Placenta previa is a condition in which the placenta, wholly or partly, is developed in the lower uterine zone. Normally the implantation of the placenta is wholly within the upper uterine segment and remains there until the birth of the fetus. When the placenta, however, is inserted in that portion of the uterine that dilates after the first stage of labor, a hemorrhage follows from the torn blood vessels, and to this abnormal implantation of the placenta with its following hemorrhage we give the name of Placenta Previa.

Generally speaking Placenta Previa may be divided into four classes.

1st. Lateral, in which the placenta extends to the lower uterine segment, but not to the internal os.

2nd. Marginal, when it barely reaches the internal os.

3rd. Partial, when the placenta partially overlaps the os after complete dilatation.

4th. Central, when placenta overlaps entire os.

All these terms are needlessly confusing and it is sufficient to make two classes, namely, complete and incomplete.

Frequency. The frequency of placenta previa is stated as follows: 1 to 1000, but no weight to be placed on statistics since figures vary from 1 to 1500 to 1 to 3000. Central placenta previa occurs in less than one-fifth of the cases.

Predisposing causes are—chronic endometritis, subinvolution, twin pregnancies.

Miller finds the cause in arrested abortions.

Osiander says that the influence of gravity should be taken into consideration.

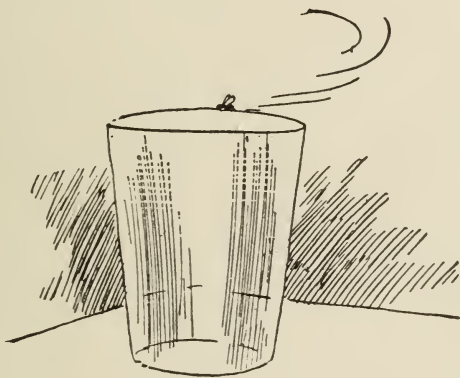
Hart maintains that vicious insertion is primary.

Hofmeier has proposed the theory that it may originate from the development of the placenta over the decidua reflexa of the lower pole of the ovum.

But taking it all together, we do not know the cause, but the condition, whatever the cause may be, is frightful.

Symptoms. Usually in the early months of pregnancy, the symptoms are slight, and yet placenta previa is frequently the cause of an unrecognized abortion. Hemorrhage is the most constant symptom. A painless, causeless hemorrhage occurring in the later months of pregnancy means placenta previa. I care not how slight this hemorrhage may be, from a few drops to a severe flooding, it means always some abnormal implantation of the placenta, or placenta previa. I have had the misfortune to see ten such cases within the last twelve years; not all were my own, some that I was called in consultation or for operative interference, and I am sorry to say, that men who do obstetrics, do not seem to realize the severity of these cases. Some men think that because the hemorrhage is not severe, that the patient is out of danger. But some of the worst cases are those where the hemorrhage is slight but continual. Therefore—any hemorrhage, no matter how slight, in the latter month of pregnancy—means to the careful obstetrician—that something is wrong, it is a danger signal. I have no use for the so-called obstetricians, who, seeing these symptoms, in the latter months of pregnancy, says: "Oh, I guess she will be alright, or she did not lose much blood," etc. Such a man, unless he has made a careful examination, and has satisfied himself that it is **not** placenta previa, is a criminal, and is responsible for the fate of the mother and child.

I urge more careful examinations in



I THEN TOOK A WALK
AROUND THE EDGE OF
A DRINKING GLASS

—Los Angeles Herald.

obstetrics, particularly when abnormal condition seems present—the examination by nurses in such, or in all cases in obstetrics, should be severely condemned.

There are several things that are characteristic of this hemorrhage, one is that the flow is most profuse in the interval between pains. During the height of the pains, the blood supply is almost entirely cut off by the contraction of the upper uterine segment; when relaxation recurs the hemorrhage reappears. It is not the amount of blood lost at the time, but the reoccurrence of this hemorrhage that proves fatal.

Diagnosis. Dr. Lee says: "A painless, causeless uterine hemorrhage in the last two months of pregnancy enables a direct diagnosis of placenta previa to be made, but the conclusion must be certified by vaginal examinations and the finding of placental tissue over the internal os."

The examination should be made with the greatest care as far as asepsis is concerned, etc. Again I wish to state, that these examinations should be made carefully and gently—because great harm has been done by rough and careless examinations.

Vaginal examination, the peculiar spongy feel of the placental tissue to the examining finger, nearly always make a diagnosis—particularly so if we take the history of the patient in consideration. Another point Dr. Lee says to be determined by internal examination is whether the placenta previa is central, lateral or marginal.

Prognosis. Placenta previa is one of the most formidable complications that occurs in pregnancy, and I am sure sacrifices more lives of mothers and children than is shown in general statistics. The cause of the great mortality of the mother: 1st, Hemorrhage. 2nd, Sepsis. 3rd, Phlebitis. 4th, Shock, due to version, which operation is frequently indicated, and which is com-

monly done when the patient is in shock at this time on account of the watchful waiting, recommended by certain authors and obstetricians.

The large fetal mortality is due to: 1st, Asphyxia. 2nd, Prematurity. 3rd, Version. 4th, Inspiration-pneumonia, (Edgar).

De Lee in his table shows that of 2153 women with placenta previa, 166 died, or nearly 8%, which is better than some years ago.

The Berlin Frauen Klinik gives 3.8%.

Futh collected in private practice 726 cases near Koblenz with 143 deaths, or nearly 20%, with infant mortality of 48%.

Figures at the Angelus Hospital for 1915 show 265 births. Deaths of babies, 5; of the 5 deaths, 3 were due to placenta previa, the mothers being treated by conservative methods. Eight Caesarian sections were done for placenta previa with no death of either mother or baby. Many of these cases I have seen, either in consultation or at times when no consultation was necessary. Still all these figures amount to little, unless we take into consideration the condition of the patient, when seen by us.

Because. 1st. Was the patient infected by careless examinations when brought to us? 2nd. The degree of the previa, total or partial. 3rd. The amount of blood lost. 4th. The previous treatment. Therefore statistics are not reliable.

We know that the highest mortality occurs in central implantation, which is true for both mother and child.

The prognosis for the mother, if she does live, is bad, due to infection, resulting in a life long invalidism.

There is no preventive treatment for this condition.

When it occurs, we face a most formidable situation. Two things we must try to accomplish are: 1st. Save the mother. 2nd. Save the child.

A patient with placenta previa should



SEEING AN UNSCREENED
WINDOW IN A NICE HOME
I WENT IN AND FOUND THE
TABLE ALL SET FOR
DINNER

—Los Angeles Herald.

be sent to a well-equipped hospital at once. Placenta previa, as a rule, can not be taken care of in the ordinary home. Explain to the patient her desperate condition. Call a consultation, **then** if she refuses to go to a hospital, tell her to get another obstetrician, who wants the job under those circumstances. (And there seems to be plenty that like to take this chance.)

Treatment. 1st. Save blood. Save the blood of the mother in some way. We can divide the treatment into two parts.

1st. Hemorrhage due to placenta previa during pregnancy.

2nd. Hemorrhage at the beginning of labor, or when the fetus is visible.

1st. During pregnancy, before labor has started and the fetus is not visible, we must stop the hemorrhage in some way, and we may try to have the patient go to term. Patient in hospital tampon in vagina. This does not stop the hemorrhage in all cases, but it will probably stop the flow. If, however, another hemorrhage starts, after packing we must empty the uterus, it is no use to wait longer.

Any of the methods employed to save the life of the mother are sufficient.

2nd. During, or at the beginning of labor, we have to deal with a different condition. We have two indications.

1st. Stop the hemorrhage and save the mother. 2nd. Empty the uterus and save the child. Stop hemorrhage. In cases of marginal placenta previa the hemorrhage generally begins during the second stage of labor. We can puncture the bag of water, so that the placenta retracts, the head may enter the lower uterine segment, and by pressure stop the hemorrhage—then if pains come on we may be able to deliver a living child. But the usual conditions we meet with are the following: A severe hemorrhage, a more or less dilated os and slight or no pains—now what are we to do? 1st. We can do a Braxton Hicks version—puncture the

membranes—go into the uterus with two fingers—seek for a foot and lead it into the vagina.

If the placenta covers the entire os, go through it at the most accessible part and bring down a foot.

After the foot has been brought down, the hemorrhage is under control, and by gentle traction, increase of hemorrhage can be controlled. Normal saline solution can be given while delivery is going on.

This method controls hemorrhage, but it sacrifices a very large number of children.

The other method is the use of some form of bag to tampon the cervix and lower uterine segment. Maurer in 1837 first brought this procedure to the attention of the medical profession.

De Lee says "The original Carl Brain bag is as good as any." Voorhees of New York has modified the bag, the so-called Voorhees, which I have used several times.

The bag, properly inserted, sometime with traction will stop the hemorrhage, will dilate the os, and give time to prepare for delivery.

However, as De Lee says, "beware of too hasty extraction through a poorly dilated cervix."

Delivery should then be done slowly. If the head is large, cervix small, we can not use force to extract baby, and (words from De Lee) "We must courageously allow infant to die."

During the treatment of the third stage many patients have been lost. Hemorrhage at this stage may be fatal. Use radical methods to control hemorrhage at this stage. In the treatment of this condition, placenta previa, there is no use to mention the so-called rapid delivery procedure—manual dilatation of os, etc., and immediate delivery of the child. De Lee says, and I most heartily agree, that such treatment is criminal. So, summing up, the treatment of placenta previa, to say the least, is not satisfactory.



STOPPED FOR A SIP OF
MILK FROM A BOTTLE
THAT WAS LEFT UNCOVERED....

—Los Angeles Herald.

I would in nearly all cases advocate (Caesarian section, it has given me better results than any other form of treatment.

With the other method I have always lost the baby and the mother has become infected, or phlebitis has developed, in one case keeping the mother in bed for nine months. She is not well yet. These results may be due to my poor obstetrics, but other men seem to have similar results.

Caesarian section is a safe operation, when done by competent men in a well-equipped hospital. It saves the mother and child. What more can we wish for?

Therefore in conclusion, in cases of placenta previa, central or partial, (the child being alive) the mother being near term and in good condition, (Caesarian section and the results will be far better than have been obtained by "watchful waiting."

I fully realize that this paper has not done justice to such an important subject as placenta previa. I am fully aware that there is nothing new in it—but if this paper will bring about a free discussion as to the treatment of this formidable condition, then I feel that it has not been written in vain.

THE DOCTOR'S VACATION.

I mentioned to my literary friend that I could not get away on my annual vacation, and that many Doctors were feeling the lack of cash. My friend was so affected he dashed off the following:

But the Doctor Man, He Docs and Docs.

Whether it blows or whether it snows,
The season comes and the season goes;
The crops get sick and the farmers blue,
The merchants kick, and the lawyers
sue,
The preachers preach and the sinners
sin,
And cares beset the souls of men—
But the doctor man, he docs and docs,

And the payless patient knocks and
knocks.

New babes are born to gather ills,
And patent "cures" and liver pills;
They marry, too, and once again
New babes are born to gather pain.
But whether they live or whether they
die,

Whether they laugh, or whether they
cry,

The poor old doctor docs and docs
The folks in silks and tattered frocks.
The merchant sends his monthly bills
And gets the cash and fills his tills;
The lawyer grabs a monstrous fee
And takes a trip o'er the well-known
sea;

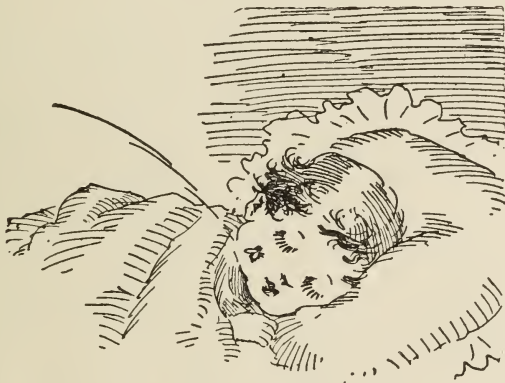
The jitney man gets his on sight,
And the burglar man collects at night,
But the doctor man, he docs and docs,
While the payless patient knocks and
knocks.

When a life-guard saves a life or two,
The people raise a how-de-do;
He gets his name in the Weekly Swim
And they make a hero out of him;
Carnegie sends an iron cross,
And musty words o'er grown with moss.
But the doctor man saves a dozen lives
Of cross-eyed husbands, lonesome wives;
He chases out in the cold, damp rain
To see a man with a chronic pain;
He sits all night by a human frost
Without a thought of sleep or cost;
He overlooks his bill to those
Who're shy on food and rent and
clothes.

At last his task on earth is done—
His cloek's run down—his works won't
run.

And as they lay him down with care
Among the folks who beat him there,
A patient says: "He's on th' shelf—
He must ha' tried to cure hisself!"

Winnipeg has been selected by a representative of a British concern as the location of a branch manufactory of surgical dressings and instruments which will give employment to about 600 workers.



SAW A BABY ASLEEP -
WALKED AROUND IT'S CHEEK
AND MOUTH - FOUND IT
VERY SWEET.....

—Los Angeles Herald.

SOUTHERN CALIFORNIA PRACTITIONER

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EDITORIAL

SPECIAL NOTICE.

During August and September, Dr. C. G. Stivers will occupy the editorial chair and act as executive officer in charge of the destinies of this publication. Yes, he has had previous experience in that capacity. So you may telephone him any news you may have for the Southern California Practitioner—or write him, if you have any speech defects.

THE NOSE — SURGICALLY AND ESTHETICALLY CONSIDERED.

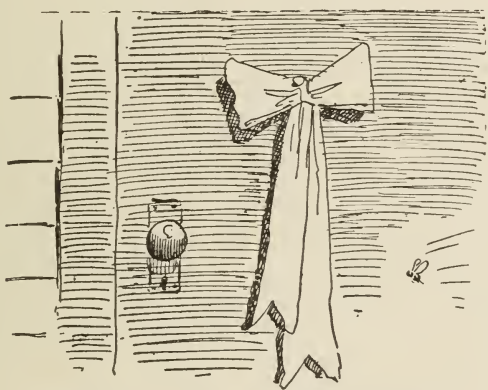
Not many years ago the surgery of the nose was extremely limited. Polyp, tumors, spurs and hypertrophies comprised about all there was done in the nose. Its mucous membrane was ruthlessly cut and bruised; turbinated bones by the bushel were to be removed by every Rhinologist. A short time ago, a prominent Oto-Rhino-Laryngologist told me that his income had been curtailed one-third by the gradual abandonment of the old operation of

removing the turbinates, usually entire. With a pair of scissors, a saw, a speculum and cocaine, many a nose was robbed of its protective, soft moist lining, to become in after years, dry, painful and filled with crusts and odor. It was such an easy operation, just like cutting off slices of bread, almost.

Since the advent of bacteriology, trans-illumination and improved instruments and technique, the nose cavities and the accessory sinuses are operated on with as much freedom and as good results as obtains elsewhere in the realm of surgery.

It takes long training, good eyesight, steady nerves and excellent surgical judgment to make a first-class Rhinologist.

One of the greatest advances in surgical rhinology has been the recognition of the necessity of keeping intact as much of the mucous membrane of the nose as possible during operations in the nose. Sub-mucous is the way nowadays, to do turbinectomies, septum



PASSED BY SAME HOUSE
A FEW DAYS LATER AND
NOTICED SOME WHITE RIBBON
HANGING ON THE FRONT DOOR...

—Los Angeles Herald.

resections and spurs, preserving the function, while meeting the indications.

It is really amazing how few really good looking noses one sees. Beautiful eyes are plentiful, pretty mouths scarcer, but the finding of a really beautiful nose is a rare event.

A really beautiful nose is perfect anatomically and esthetically, like the keystone in an arch, finishing and embellishing the features it adorns.

American faces are such a conglomeration of crowded features, such a mixture of all the assembled architectural styles of Europe, Asia and Africa, that one cannot speak of a typical American nose. I have usually found them too big for the rest of the face. If they are straight they fail of beauty by being narrow and being flanked by a pouted upper lip and protruding upper teeth, sadly in need of Orthodontia. The noses of children are almost the best indices to their ages and development. A child's nose is commonly only a snubby pug retroussé and barely lifted above the level of the cheeks. The millions of tonsils and adenoids being removed during our generation will undoubtedly result in a betterment of the facial adornments of future peoples. I would like to come back to Earth in 500 or 1000 years to trace the results of all the tonsils and adenoid operations I have performed in children.

DEATH OF DR. K. D. WISE.

The death a few weeks ago of Dr. Wise and a few months ago of Dr. H. S. Orme quickens a flood of reminiscences. They were both practicing in Los Angeles forty-five years ago with offices in the Lan Franco Building at the junction of Main, Temple and Spring Streets. They were bitter enemies and their office doors faced each other. Los Angeles was then a town of five thousand people and every person knew every other person's business, which tended to fan the flames of

animosities. Dr. Wise was from Kentucky and Dr. Orme from Georgia. Their trouble culminated one day on Main street when they met and drew their guns on each other, but no blood was shed.

A few years after this pseudo tragedy a physician, who is now a very prominent practitioner in Los Angeles, wanted to speak to Dr. Orme, but by mistake rang up the telephone of Dr. Wise.

"What is wanted?"

"Is this Dr. Orme?"

"No, this is a gentleman!" and the receiver was hung up with an emphatic click.

At one time Dr. Wise was the chief surgeon in this city. He was impressive both in stature and mien. Although his K. stood for Kenneth, yet owing to his bearing people generally interpreted his initials K. D. to stand for "King David," by which title he was frequently mentioned. He was of a peculiar disposition and led from choice, a life of professional isolation until he had an unjust malpractice suit, when he realized that no man can safely try to live independently of his fellow man. The profession stood by him successfully in his hour of trouble regardless of the past.

To the best of our knowledge he belonged to no medical society. During his later years he was absorbed in the study of the occult. It was startling to hear from his lips his personal conversation with those who are dead and gone. Dr. Wise graduated from the Jefferson Medical College in the class of 1865.

He was a positive, aggressive character and although he had his circle of friends, was not by nature particularly genial.

If you have any business at the bank, put it off till 2 o'clock or a little later, as it looks more business like to rush in just as the bank is closing.

EDITORIAL NOTES

Dr. A. B. Leffler has returned from a trip East.

Dr. Stivers has built a cabin in Pa-coima Canon.

Dr. F. W. Rinkenbeger leaves soon for war studies in Europe.

Dr. Lloyd Mills was at the preparedness training camp at Monterey.

Dr. Paul Durfee has taken up his work as Health Officer of Bisbee, Ariz.

Dr. C. H. Montgomery, with family and a friend, motored to Bear Valley recently.

Dr. E. P. Smart of Lankershim is building a summer home in the mountains back of San Fernando.

Roentgen Diagnoses of the Upper Air Passages is the title of a reprint by Dr. John J. Kyle of Los Angeles.

Dr. Victor La Tour and his bride returned from their honeymoon to the home of the bride's parents, South Pasadena.

Dr. Donald Frick and family and Dr. and Mrs. Hill Hastings were guests at Idyllwild in the San Jacinto Mountains, recently.

The Parent Teacher Helping Station or clinic building is being brought to completion, by the heirs of the late Mr. O. T. Johnson.

Maj. E. E. Persens, Medical Corps, U. S. A., champion mosquito exterminator of the universe, was a recent visitor in Los Angeles.

Dr. Robert V. Day has removed his offices to the eleventh floor of the Brackett Building, 527 W. 7th St., opposite the Brockman Bldg.

Desirable office to rent in suite with four other doctors. Investment Bldg., 8th and Broadway. For particulars phone Dr. Armstrong, 10551.

Dr. J. G. Mackey of San Fernando has built himself an office building on the main street of that old Mission City. It is in Mission style of architecture.

WANTED—By trained office assistant, position in physician's office, stenographer and bookkeeper; references. Call West 1241. Address 1506 Arapahoe Street.

Dr. C. G. Stivers lectured on "Speech Defects," and showed two patients to the psychology class of Miss Grace Fernald, at the University of Southern California, on Tuesday, August 1st.

Dr. Lulu Peters, chairman of Health, Los Angeles District Board, California Federation of Women's Clubs, says, The home is the most interesting, the most profitable study for women because it is the center of all the issues of life.

The Obstetrical Quiz For Nurses, a monograph on obstetrics for the graduate and the under-graduate nurse in the Lying-In-Room by Hilda Elizabeth Carlson, published by Rebman & Co., 145 West 36th Street, New York City, price \$1.50, is a valuable addition to the literature for nurses. We especially commend the chapters on "Care of Premature Infants," "Infant Feeding" and "Nitrous Oxid Gas-Oxygen Anesthesia." Every nurse who buys this book and refers to it frequently will be far better equipped by the knowledge thus gained.

At Roosevelt Hospital, New York, the open air treatment has been proven more effective for children suffering from pneumonia, tuberculosis, anaemia, cholera, marasmus and for those convalescing from any disease.

Dr. R. S. Freeman describes in the American Journal of Medical Sciences how children with pneumonia are

treated. After a dose of castor oil they are put to bed on the roof (which is partly covered); their extremities are kept warm by means of ample bed clothes and hot water bottles. Recovery is remarkably rapid and the mortality very small.

BLOOD PRESSURE TESTS.

Dr. W. W. Beckett, Medical Director of the Pacific Mutual Life Insurance Company, is the author of a booklet "The Blood Pressure Test." It is replete with valuable points and in conclusion says: "The preferable time to take blood-pressure readings is midway between meals.

The applicant should be in a comfortable position, with the left arm extended and resting on a table. See that the applicant is free from all excitement, muscles relaxed and mentally composed.

Take all subsequent readings at the same time of day and with the applicant in the same position as when first taken. At least three readings should be taken at the same sitting as a check on the first.

Consume no more time in taking readings than is necessary. Two or three minutes is sufficient.

Do not constrict the vessels more than a minute at one time.

Be sure to give both the systolic and diastolic readings.

If the readings are abnormal, without a discoverable impairment, tests on a subsequent date should be reported.

Familiarize yourself with your blood

pressure instrument, follow instructions carefully, be sure of your technique and satisfactory results will be obtained."

Goat milk is, we are glad to know, being used more and more in Los Angeles and vicinity. Physicians will be interested to learn that: According to the Annual Reports of the Bureau of Animal Industry (U. S.), covering Federal Inspection of Animals Slaughtered for Food, there were inspected during the eight years of 1907 to 1914, inclusive, 579,617 goats, of which not a single animal was condemned for tuberculosis. On the other hand, it is a well-known fact that the condemnation of cows on this account is astonishingly large, 29,738 having been condemned during the single year of 1914, out of the total slaughtered. The dairy cow produces only four times its bodily weight of milk in a year, a good milch goat produces twelve times its weight in the same period. During a ten months' period of lactation, a goat may be expected to average three quarts of milk a day. There are many very interesting characteristics of the pure-bred milch goat. Unlike other grazing animals they refuse to graze over the same pasture twice in succession, or even where another goat has grazed recently—a week's interval is necessary. Also dry food in the dairy barn must alternate. They refuse to drink from dirty troughs or unfresh water. They will not step in mud—being very particular about their feet—consequently only well-drained pastures are used.

BOOK REVIEWS

A MANUAL OF PRACTICAL LABORATORY DIAGNOSIS. By Lewis Webb Hill, M.D., Graduate Assistant, Children's Hospital, Boston. With eleven figures and eight plates, four in colors. W. M. Leonard, Publisher, Boston. 1916.

The worth-while laboratory tests that a practical medical man needs, are here put together in a small and compact volume. This is gotten up in such a

way that medical students, and house officers doing their hospital ward and dispensary work, can carry it in their pockets for ready reference, without going to the trouble of hunting through all the various alternative methods of performing a test given in most of the larger books. Such things as tissue

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by irritating the delicate lining of the intestines and inducing undue peristaltic activity. On the contrary, it conserves strength by lubricating the entire alimentary canal, thus assisting in a more complete evacuation of the bowel content.

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staining and fixing, the Wassermann reaction, the gold chloride test, etc., have been omitted, as these are not ordinarily performed by medical students, house officers, and general practitioners, for whom this book is intended.

SEX PROBLEMS OF MAN IN HEALTH AND DISEASE. A Popular Study in Sex Knowledge. By Moses Scholtz, M.D., Chief of Clinic and Clinical Instructor in Dermatology and Syphilology, Medical Department of the University of Cincinnati; Fellow of the American Medical Association, Ohio State Medical Society, Academy of Medicine of Cincinnati, Society of Moral and Sanitary Prophylaxis, etc. Stewart & Kidd Company, Cincinnati. 1916.

From page 23 we quote: "Spermatozoa, or human embryos, are microscopically small living cells, which resemble very much in appearance tadpoles." Such misinformation can scarcely be deemed a proper guide for lay instruction in sex matters. There is so much with which we cannot agree, that we are unable to recommend the volume to either the profession or the laity.

THE PRACTICAL MEDICINE SERIES. Comprising ten volumes on the year's progress in Medicine and Surgery. Under the general editorial charge of Charles L. Mix, A.M., M.D. Volume III, **THE EYE, EAR, NOSE AND THROAT**, edited by Casey A. Wood, C.M., M.D., D.C.L., Albert H. Andrews, M.D., and George E. Shambaugh, M.D. Series 1916. The Year Book Publishers, 327 La Salle Street, Chicago. Price of this volume \$1.50. Price of the series of ten volumes, \$10.00.

This well-known series has established its right to a place in the physician's library. This volume and some of those recently issued, have shown decided improvement in the way of illustrations. There is nothing that can fully take the place of a good illustration.

ULTRA-VIOLET LIGHT by means of the Alpine Sun Lamp. Treatment and Indications. By Hugo Bach, M.D., Bad Elster, Germany. Authorized translation from the German. New York: Paul B. Hoeber, 1916. Price \$1.00.

This is a handy little monograph on the ultra-violet light and its uses. Although the use of ultra-violet light has secured recognition in therapeutics, there is still much that is unknown concerning this new method of treatment.

This little book places before the reader a fund of information on the subject.

AMERICAN MEDICAL EDITORS' ASSOCIATION.

At the call of the President, the Executive Committee of the American Medical Editors' Association, met in New York at the Martinique Hotel, on April 25th. Those present either personally or by proxy were:

President Edw'd C. Register of the Charlotte Medical Journal.

Dr. C. F. Taylor of the Medical World.

Dr. G. M. Piersol of American Journal of Medical Sciences.

Dr. A. S. Burdick of Amer. Journal of Clinical Medicine, and your Secretary.

After due consideration it was decided in view of the successful meeting held last year in New York, and as well as on account of a number of requests from members who want to attend our meeting but cannot go to Detroit, to hold our next annual meeting again in New York with headquarters at the McAlpine Hotel, on October 25th and 26th, with the banquet on the 26th.

The Executive Committee, in deciding to again meet in New York, wishes to impress upon the members of the American Medical Editors' Association, that their action is not to be taken as establishing a precedent in meeting away from the American Medical Association or not at the time of the American Medical Association, but for reasons as above expressed.

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THE DIAGNOSIS OF THE INTERNAL SECRETORY DISEASES.

BY HENRY R. HARROWER, M.D., F.R.S.M. (LOND.), LOS ANGELES, CAL.

V.

The Adrenal Glands in Health and Disease.

Perhaps more profitable research has centered around the adrenal glands during the past ten years than around any of the other glands of internal secretion. At least many epoch-making discoveries of their important rôle have been made quite recently.

Unfortunately the clinical application of this new knowledge has not been very extensive as yet; and many times the physician's sole appreciation of adrenal disease consists of a hazy recollection that Addison's disease is said to be a tuberculous involvement of the adrenal glands—and that it is incurable.

Some things about the adrenals are very well known. We are in the habit of using adrenalin almost every day and know that it exerts a very decided influence upon the circulatory system, both in physiology and in therapy. We also know that the adrenin continuously produced by the

adrenal medulla is the principal regulator of vascular tone and that it performs a number of other useful services for the body. But, somehow or another, it is the exception to find a proper clinical appreciation of the importance of the work of the adrenals and how easily their functions may be influenced slightly or seriously with corresponding minor or important effects on the body as a whole.

Ten years ago T. R. Elliot, of London, showed us that adrenin virtually controlled the autonomic and sympathetic nervous systems. Sergent, of Paris, proved this relationship in numerous experiences in his clinical work. Still more recently Cannon, of Harvard, has given us an entirely new conception of the extreme importance of adrenin to the human economy especially in so far as its variations are related to the emotions.

Some Adrenal Physiology

A brief exposition of the physiology of the adrenal glands will prepare us for a better understanding of their secretory disorders. The chromoffin hormone otherwise known as adrenin, arising from the medullary portion of the adrenals, as well as in other chromophil cell collections in different parts of the body, exerts a very remarkable and extended influence upon numerous structures which are controlled by the sympathetic. Adrenin raises the blood pressure and has much to do with its maintenance at the average level; it dilates the pupils and excites the flow of tears and saliva; it contracts the minute muscles of the hairs (**erectores pilorum**); it undoubtedly is concerned with the function of the sweat glands and, in fact, the blood supply of the skin and, in addition to all this, it seems to have a certain influence upon the gastric, uterine and intra-abdominal muscles in general.

Adrenin is probably the principal factor in the maintenance of the normal tone of the body, and disturbances in its production disorganize the so-called "sympathetico-tonus," causing it to be deficient or abnormally increased as the case may be. The condition known as "adrenin sensibility" is now being used as the basis for several tests for sympathetic functioning which will be referred to later.

The adrenals are particularly susceptible to what have been termed the "emergency conditions." Cannon's well checked experiments have definitely proved that the emotions, including pain, rage, fear and hunger (perhaps it will be shown later that even worry has a similar effect) influence the secretory powers of the adrenals, with an immediate response due to the hyperadrenia this produced. This condition passes rapidly and as soon as the glands have been sufficiently overworked and the stimulation continues with no opportunity for recuperation,

a serious condition of hypoadrenia supervenes.

While very little therapeutic advantage has been taken of the results of this work, we can now see rational explanations for a number of phenomena which quickly can be called to mind. Practically the whole of the results of Crile's investigation of "the kinetic system" and his now fairly well known method of "anoci-association,"* are really dependent upon the prevention by suitable measures of any undue stimulation of the adrenal glands, and hence the serious consequences of acute hypoadrenia are thereby forestalled.

Before considering the symptomatology of the functional adrenal secretory dyscrasias, it should be recalled that not only are the emotional factors already referred to capable of causing this adrenal syndrome, but that certain of the hormones produced in other organs, when present in the blood stream in unusual amounts (see further references to this in the chapter on the ovaries) may have a similar stimulating effect. We must also remember that toxemia of intestinal or bacterial origin exerts a like influence and that it has been shown that conditions associated with extremely high blood pressure cause adrenal disorder, probably by producing intra-adrenal hemorrhages. One of the best established "symptoms" of senility is of adrenal origin.

With these facts in mind we can understand that severe emotional conditions, sudden or prolonged; acute

*The kinetic system, according to Crile, embraces the adrenals, thyroid, brain and muscles, which cooperate to "drive" the body. The adrenals are probably the most important of these kinetic organs and the method of pan-anesthesia named "anoci-association" consists in supplementing the usual anesthetic measures by removing such mental and nervous stimuli (by preventing fear and pain, and by "blocking" certain nerves) as would tend to stimulate the adrenals and by their depletion bring on shock and collapse.

infectious diseases with the invariable accompanying toxemia; and chronic infections, as tuberculosis or intestinal stasis (which is, after all, practically a chronic infection with mechanical involvement added) would be likely to bring about certain changes in the activities of the organism as a result of the influences due to adrenal de-
gagement.

Hyperadrenia

Hyperadrenia is not nearly so common a symptom as hypoadrenia, although it needs must be just as frequent, for the adrenal depletion of which we shall shortly speak is really a terminal condition which results from the exhaustion following excessive stimulation. The reason that hyperadrenia is not more commonly detected is probably due to the fact that adrenin is oxidized in the blood with great rapidity, and that if large quantities of it happened to be brought forth, they are destroyed very shortly after they are produced. Confirmation of this destructive influence is noted following the use of adrenalin for therapeutic purposes, as well as in many experiments on animals which uniformly show that once this hormone gets into the blood, it is very quickly destroyed.

However it will be proper to enumerate several clinical findings which are probably of adrenal origin, since the treatment is largely preventive rather than direct, for to realize that certain factors are unduly stimulating the adrenals is to realize that these factors must be abated.

An unusual tendency to goose pimples, without any ordinary reason therefor, may be directly due to this condition. Probably this accounts for the not uncommon association of this phenomenon with fright. Chills, which are merely severe vaso-motor disturbances with muscular spasm, are commonly produced artificially by injections of adrenalin (especially following

its use in the control of asthma), and I am by no means sure that this chief manifestation of malaria is not due to a temporary and excessive stimulation of the adrenal glands by the sudden unloosing of the toxins of the plasmodia. Further, the severe reaction following this positive phase of malaria, with its prostration, asthenia and depression simulates the symptom complex of hypoadrenia, as we shall shortly see.

This is a phase of the study of the adrenal glands that is not yet worked out, and this suggestion, which I believe is original, has neither been denied nor affirmed. Of course if this hypothesis is tenable, it would apply equally to pneumonia, typhoid fever and other acute toxemias where severe adrenal depletion is almost invariably an ultimate outcome.

In studying the relation of the adrenal glands to the toxemia of tuberculosis, Pottenger remarks that the continued stimulation of the adrenals and the continued pouring into the blood stream minutely increased amounts of adrenin, has the effect of producing a prolongation of the condition which is originally brought about by sympathetic stimulation. It is suggested that this condition of hyperadrenia is responsible for the dry mouth frequently seen in tuberculosis, and that other symptoms of sympathetic origin such as the sudden and seriously impaired digestion and, particularly, the rapid heart action, are really the result of excessive adrenal stimulation.

It is quite possible that certain cases of purely functional hypertension, with no renal, cerebral or vascular findings demonstrable, are really due to hyperadrenia, usually of toxic origin. At least the interesting though academic researches of Zimmern and Cottentot, of Paris, seem to confirm this. They were able to reduce very high tensions by properly dosed roentgenization of

the areas over the adrenals—to my mind a very serious undertaking.

There is still another form of hyperadrenia which must be mentioned though it is very rare. I refer to the condition known as “hypernephroma,” which is an excessive proliferation of the adrenals usually involving the cortical tissue more than the medulla. The chief manifestation of this is a remarkable increase in the development and growth in early life (this is much more common in young subjects) with premature sexual development. Bullock, Sequeira and others have demonstrated a relation between the presumed internal secretion of the adrenal cortex and the gonads. At all events in cases of this disease the findings are chiefly referable to the gonad functions—a child of eight or nine may be quite as large as an adult with marked overdevelopment, physical and functional, of the genitalia, and hypertrichosis. It is a difficult, practically hopeless, surgical condition.

Adrenal Insufficiency

Since the adrenals are so susceptible to so many outside influences it is likely that they would be easily “worn out” and, as a matter of fact, functional hypoadrenia is quite common. From a practical standpoint this is an extremely important symptom complex. It is quite some years since Sajous began to emphasize the importance of this condition, and while his opinions were scouted and some of his ideas declared visionary it must be admitted that our present knowledge of this subject is very much in harmony with the following quotation from Sajous’ monumental work: “Functional hypoadrenia is the symptom complex of deficient activity of the adrenals due to inadequate development, exhaustion by fatigue, senile degeneration, or any other factor which, without provoking organic lesions in the organs or their nerve paths, is capable of reducing

their secretory activity. Asthenia, sensitiveness to cold and cold extremities, hypotension, weak cardiac action and pulse, anorexia, anemia, slow metabolism, constipation and psychasthenia are the main symptoms of this condition.”

Hypoadrenia is a complication of all the serious acute infectious fevers, since the adrenals are so intimately connected with the “driving” of the body and are so susceptible to toxemia that the ultimate reduction of the accustomed adrenal stimuli is responsible for a slowing down of many of the sympathetic-controlled functions of the organism. Too often this sympathetic asthenia is the actual cause of death from diseases of this character.

There are three forms of hypoadrenia which differ sufficiently from one another to be discussed separately:

(1) Functional hypoadrenia—a temporary deficiency in the production of the chromaffin hormone shown most frequently by a tardy response of the circulatory system to its accustomed stimuli and the development of a condition of circulatory inefficiency, the so-called “hyposphyxia” of Martinet. This is a condition of circulatory semi-aphyxia with venous stasis, insufficient arteriolar circulation with cold extremities and occasional slight blueness (often a mottled appearance) of the skin on different parts of the body, especially the exposed parts. In such individuals the blood pressure is usually very low, although it has been shown that extreme degrees of tension may cause a functional insufficiency of the adrenals by localized hemorrhage into the glands.

Urticaria and other severe vasomotor skin symptoms are among the well marked findings in persistent hyposphyxia, while lesser degrees may cause flushings and sensations of passing distress localized in various areas of the skin. The adrenal origin of some forms of urticaria is seemingly con-

firmed by the occasional "miraculous" disappearance of large and most uncomfortably wheals following a single hypodermic injection of from 5 to 10 minims of adrenalin solution.

With this we expect to find varying degrees of asthenia or adynamia. Exhaustion with slight cause is usual. According to Tom Williams mental exertion, even the simplest, often causes so much weariness and exhaustion as to be prohibitive. Mental elasticity is lost and there is both mental and physical depression with the fear that the individual cannot now accomplish their accustomed good mental work; and the story that they "have lost their nerve." With this one frequently notes a fearlessness of making wrong decisions and a vacillating and indecisive frame of mind.

(2) Progressive hypoadrenia. Here we expect more than the mere functional derangement. This is really another name for the disease we have been taught was first named by Addison in 1855 which, like all organic diseases, may be seen in differing forms and stages. The main symptom is the aggravated asthenia with marked myasthenia. In well advanced cases there is a localized bronzing of the skin and mucous membranes due to the deposition of a dark pigment of undecided origin. Extreme cardio-vascular debility is the rule and the blood pressure may be as low as 30 to 50 mm. Hg. Varying gastro-intestinal disturbances are usual. Fortunately this disease is rare and unfortunately its outcome is hopeless, though temporary relief has followed adrenal medication.

Lawrence in his recent consideration of "Some Aspects of Hypotension" connects hypofunction of the adrenal glands with weakness and apathy, marked fatigability and a tendency toward vertigo. These are merely variations in degree of the classical symptoms first reported by Addison.

(3) Terminal hypoadrenia. This is the extreme functional adrenal insufficiency which has already been briefly mentioned. This occurs in the final stages of fatal infectious diseases. For instance the principal clinical manifestations of Asiatic cholera (the algid stage) are adrenal in origin and, remarkably enough, have been promptly and successfully controlled by heroic doses of adrenalin, for in such cases the tolerance to this drug is apparently greatly increased and as much as an ounce of the commercial 1:1000 solution well diluted with saline solution has been given intravenously during a single day with splendid results (Naame).

Shock, collapse, cardiac failure and distressing asthenia are terminal findings in this class of cases. Distressing meteorism is present and is presumably due to functional intestinal paresis which, by the way, can be experimentally produced by fright or toxemia and the resulting acute hypoadrenia. With these dread symptoms there is often found a noticeable reduction in the reaction of the organism to urgently needed medication, for with the adrenal activities suspended the responsiveness of the body to stimuli of this character is practically nil.

The ominous sign of a suddenly reduced temperature is often seen and is due to the same cause. In such cases one can invariably produce Sergeant's "ligne blanche surrenale", a dermatographic sign which consists of a white line upon the skin which follows pencilling the abdomen with the finger nail, and sometimes lasts for two or three minutes. This valuable clinical sign is said to be pathognomonic of acute hypoadrenia and is very easily elicited.

In cases of the character just considered, despite their severity, the therapeutic test is often both encouraging and confirmatory, for the response to hypodermic or intravenous injections of

adrenalin solution and, in many cases, the early administration of this remedy by mouth, is many times nothing short of marvelous. At times I feel that this phase of adrenal medication deserved to be classed with thyroid in myxedema and quinine in malaria. At least it is worth recommending both as a prophylactic of such ultimate results and as a last resort in their treatment.

Neurasthenia as an Adrenal Syndrome.

This chapter should not be closed without a short consideration of the relation of adrenal dysfunction to neurasthenia. Minor functional hypoadrenia is more common than some have appreciated, and the fact that there is a psychic origin as well as the other physiologic causes already considered, allies it to the fashionable "neurasthenia" of today. In fact some have stated that what is improperly called "neurasthenia" is not a disease per se, but really a symptom complex of ductless glandular origin and that the adrenals are probably the most important factors in its causation. Campbell Smith, Osborne, Williams and others, including the writer, have directed the attention of the profession to the importance of the adrenal origin of neurasthenia (though a pluriglandular dyscrasia is practically always discoverable) but so far this is not understood as well as its frequency and importance warrant.

The subject is too large to receive exhaustive consideration here, but a few quotations from recent literature will firmly establish the importance of this angle from which to study this common and annoying symptom complex.

Quoting first from the *Journal A. M. A.*, (Dec. 18, 1915, p. 2166): "The typical neurotic generally has, if not always, disturbance of the thyroid gland. The typical neurasthenic probably generally has disturbance of

the suprarenal glands on the side of insufficiency. The blood pressure in these neurasthenic patients is almost always low for the individuals, and their circulation is poor. . . . A vasomotor paralysis, often present, allows chillings, flushings, cold or burning hands and feet, drowsiness when the patient is up, wakefulness on lying down and hence insomnia. There may be more or less tingling or numbness of the extremities."

Again Kinnier Wilson in his monograph on "The Clinical Importance of the Sympathetic Nervous System" makes the following pertinent remarks: "Many of the common symptoms of neurasthenia and hysteria are patently of sympathetic origin. Who of us has not seen the typical irregular blotches appear on the skin of the neck and face as the neurasthenic subject 'works himself up into a state'? The clammy hand, flushed or pallid features, dilated pupils, the innumerable paresthesias, the unwonted sensations in head or body, are surely of sympathetic parentage. In not a few cases of neurasthenia symptoms of this class are the chief or only manifestations of the disease. Here, then, is a condition of defective sympatheticotonus; may it not have much to do with impairment of function of the chromophil system? . . . There does not appear to me any tenable distinction between the asthenia of Addison's disease and the asthenia of neurasthenia. Cases of the former are not infrequently diagnosed as ordinary neurasthenia at first. It is difficult to avoid the conclusion that defect of glandular function is responsible for much of the clinical picture of neurasthenia."

Later this author makes the following apothegm: "Sympathetic tone is dependent on adrenal support, and until the glandular equilibrium is once more attained sympathetic symptoms are likely to occur."

Adrenin Sensibility.

As the art of clinical diagnosis is perfected we are having brought to our attention numerous "tests" of function and several of these are dependent upon a condition of hormone balance involving the adrenals. This has been called "adrenin sensibility" and the best known test based on this is that of Loewi which consists of instilling a few drops of adrenalin solution (1:1000) into the conjunctival sac. Without going into a rather complicated subject—the study of the hormone balance is not yet very simple—marked dilatation of the pupil occurs in 30 to 60 minutes in pancreatic diabetes, and this test has been used to confirm suspicions as to the waning internal secretory powers of the pancreas of which more will be said in a later chapter.

This same test is of value in Grave's disease and a dilatation following conjunctival instillations of adrenalin solution has also been proposed as a means of determining thyroid hyperfunction.

We cannot take space to explain the *raison d'être* of these tests but recommend them as confirmatory measures only.

Schultz has advanced an almost identical test for incipient dementia praecox and asserts that marked mydriasis will follow in about ten minutes after the instillation as above and that the pupillary dilatation will last as long as half an hour. Parenthetically it may be well to remark that Dunlop Robertson believes that the catatonic type of dementia praecox is due to hyperadrenia.

715 Baker Detwiler Bldg.

The title of the next article in this series will be "The Diagnosis of Disorders of the Pituitary Body." Attention is again directed to the opportunity afforded to readers of *The Practitioner* to send in questions or short case reports for consideration and answer in these columns. There is no charge for this service.—ED.

DR. JOHN HALL—SHAKESPEARE'S SON-IN-LAW.*

BY WALTER LINDLEY, M.D., LOS ANGELES, CAL.

The tercentenary of the death of William Shakespeare occurs April 23, 1916, the tercentenary of his birth having been on April 23, 1864. While memorial pageants on this tercentenary are being held throughout the civilized world, except where there is actual warfare, yet for many years each twenty-third of April has witnessed Shakespearean birthday celebrations in many places, and particularly in the town of his birth, Stratford on Avon.

It was my privilege to participate in this annual occasion in his natal town April 23, 1909. A procession composed of two thousand people formed in front of Shakespeare's birthplace. Our ambassador, the late Whitelaw Reid, and

the Mayor of Stratford on Avon led us. Each person carried a posy of daffodils, narcissus, and other spring flowers. The walk began at 10 a.m., our objective point being the grave of Shakespeare in Holy Trinity Church, a distance of about one mile. It was in truth a journey from the cradle to the grave. We paused, when about half way, at the Latin School where the bard was a student, and here the present pupils of that school joined us. Soon we were in the sacred churchyard, marching four abreast under the archway formed by an avenue of great old elms, into the beautiful church, passing the font where Shakespeare was baptized, to our seats. After a brief serv-

*Read before the Los Angeles County Medical Association, April 6, 1916.

ice of song and prayer and an inspiring address by Ambassador Reid we all, one by one, stepped to the chancel and dropped our little floral tribute on the poet's grave.

On the stone over the grave is written:

"Good friend for Jesus sake forbear
To digg the dust enclosed here;
Blest be ye man ty spares the stones,
And curst be he ty moves my bones."

Here, also, are the graves of Shakespeare's wife, Anne Hathaway; their daughter Susanna, and her husband, Dr. John Hall.

That Shakespeare and his family were given the most prominent place of burial in this noble church; that the home of his mother, the childhood home of his wife, and the house where he was born were all good substantial attractive houses—all go to prove that Shakespeare and his family were the most prominent citizens—outside of the nobility—in Stratford on Avon.

Books have been written treating on Shakespeare's extended knowledge of medicine and allied subjects. It is in "Romeo and Juliet" that Benvolio says:

"Take thou some new infection to the eye,
And the rank poison of the old will die."

Thus forestalling Hahneman in his "Similia Similibus Curantur" and at the same time showing a vision of and faith in antitoxins.

Where can a more appealing picture of insomnia be found than in "King Henry IV?" Here the king says:

"How many thousands of my poorest subjects
Are at this hour asleep, sleep, gentle sleep,
Nature's soft nurse, how have I frightened thee,
That thou no more wilt weigh my eyelids down
And steep my senses in forgetfulness?
Why, rather, sleep, liest thou in smoky cribs,
Upon uneasy pallets stretching thee,
And hush'd with buzzing night-flies to thy slumber,

Than in the perfumed chambers of the great.

Under the canopies of costly state,
And lulled with sounds of sweetest melody?

O thou dull god, why liest thou with the vile

In loathsome beds; and leav'st the kingly couch?

* * * * *

Wilt thou upon the high and giddy mast
Seal up the ship-boy's eyes and rock his brains

In cradle of the rude imperious surge?

* * * * *

Canst thou, O partial sleep! give thy repose

To the wet sea boy in an hour so rude;
And in the calmest and most stillest night,

With all appliances and means to boot,
Deny it to a king! Then, happy low, lie down!

Uneasy lies the head that wears a crown."

* * * * *

It is in "The Winter's Tale" that Antigonus says:

"I have three daughters, the eldest is eleven,

The second, and the third, nine; and some five;

If this prove true, they'll pay for't by mine honor.

I'll geld them all; fourteen they shall not see.

To bring false generations."

In this Shakespeare places fourteen as the age of beginning menstruation and indicates that oophorectomy was considered a reasonable operation over three hundred years ago.

Nowhere can the alienist find a more agonizing appeal for help than in the well-known lines from "Macbeth," and that appeal is almost as hopeless today as it was then:

Macbeth:

"Canst thou not minister to a mind diseased;

Pluck from the memory a rooted sorrow;

Raze out the written troubles of the brain;

And, with some sweet oblivious antidote,

Cleanse the stuff'd bosom of that perilous stuff,

Which weighs upon the heart?"

It is in "Pericles," written after Dr. Hall became Shakespeare's son-in-law, that the physician Cerimon opens the chest containing the body of Thasia and says:

"Look how fresh she looks!

Make fire within:

Fetch hither all the boxes in my closet,
Death may usurp on nature many hours,
And yet the fire of life kindle again

The o'erpressed spirits. I heard of an
Egyptian

That had nine hours Jien dead,

Who was by good appliances recovered.
Well said, well said; the fire and the
cloths,

The rough and woful music that we
have,

Cause it to sound beseech you,

The vial once more: how thou stirr'st,
thou block!

The music there! I pray you give her
air.

Gentlemen,

This queen will live; nature awake; a
warmth

Breathes out of her: She hath not been
entranc'd

Above five hours: see how she 'gins to
blow

Into life's flower again."

Thus we might go on reading by the hundred quotations showing Shakespeare's intelligent familiarity with every branch of medicine.

How did a man, not a physician, secure such a vast fund of knowledge in a profession to understand the elemental principles of which requires years of study?

First, his was probably the most comprehensive mind of all time; second, intimate association with physicians, among whom was his son-in-law, Dr. John Hall, an eminent member of the profession. Dr. Hall was but twelve years younger than his father-in-law, who lived either as a neighbor or in his family for the last nine years of his life.

Shakespeare was eighteen years old when he married Anne Hathaway, who was his senior by eight years. May 26, 1583—five months after their marriage—Susanna was born. On February 1,

1585, twins—Hamnet and Judith—were born.

Thus before he was twenty one Shakespeare was the father of three children. The son Hamnet died before he was twelve years old; the daughter Judith married and bore children, but they all died during childhood. Susanna married Dr. John Hall on June 5, 1607, she being twenty-four and the doctor thirty-one.

One of the writers of that day says Dr. Hall "had a large and gainful practice." He attended the families of Lord Say, the Earl of Shrewsbury, Earl of Northampton, then President of Wales, and, in fact, all of the leading families of that part of England.

Dr. John Bird, Linaere professor in the Medical College, London, speaking of Dr. Hall, and of the book he wrote entitled "Select Observations on English Bodies of Eminent Persons in Desperate Diseases," says: "The learned author lived in our times, and in the county of Warwick, where he practised many years, and in great fame for his skill, far and near. Those who seemed highly to esteem him, and whom, by God's blessing, he wrought these cures upon, you shall find to be, among others, persons noble, rich, and learned. And this I take to be a great sign of his ability, that such who spare not for cost, and they who have more than ordinary understanding—nay, such as hated him for his religion, often made use of him."

Dr. Hall died in 1635 and eight years later (1643) his widow, still in the beautiful property known as New Place, entertained for three days Queen Henrietta Maria, wife of Charles I, and her retinue. The queen was on her progress to meet the king, and proceed with him to Oxford. Shakespeare's daughter, a physician's widow, had as her house guest the Queen of England. This again gives an idea of the eminence of Shakespeare's family.

The Halls had one child, Elizabeth, the only grandchild of Shakespeare that reached adult age. She was born in 1607 and was nine years old when Shakespeare died. One can reasonably look backward three hundred years and see the King of Poets, who was noted for his loveliness and usually spoken of by his contemporaries as "Sweet Shakespeare," strolling through the extensive gardens of his favorite daughter, hand in hand with his little grandchild. Thus was spent the evening of his life.

Elizabeth, in 1626, married Thomas Nash, who died in 1647, and was buried with the Shakespeare family in the chancel of Holy Trinity Church. After being a widow two years this doctor's daughter, then forty-two years old, married Sir John Bernard, an eminent nobleman, who had been knighted by Charles II. She never had a child and at her death in 1670 there was an utter extinction of the progeny of William Shakespeare, which thus endured only fifty-four years.

Joseph Hunter, nearly a century ago, said: "It is rather a striking fact in the history of the human race, that, when there are men preeminently great, the issue, if any, generally becomes soon extinct." Chaucer, Sidney, Shakespeare, Milton, Dryden, Pope, Bacon, Locke, and Newton have no one left to claim them as ancestors. How easy we Americans could make a similar list: Charles Sumner, Wendell Phillips, Walt Whitman, Edgar A. Poe, and George Washington, while Abraham Lincoln's only grandson died several years ago.

Returning to the book of which Dr. Hall is author: It was in 1644, nine years after the doctor's death, when Oliver Cromwell's troops occupied Stratford on Avon, that James Cooke, surgeon in the army and author of a work entitled "The Marrow of Surgery," called on the widow. Mrs. Hall received him pleasantly, and after she had allowed him to look through her

late husband's library she sold Dr. Cooke some notebooks that Dr. Hall had evidently prepared for publication.

These notebooks were a selected record in Latin of several hundred notable cases that he had attended. Dr. Cooke translated, edited, and issued this work. Three editions were issued: in 1657, 1679, and 1683 respectively. The first edition is now worth \$250; second, \$100; third, \$20. It is very interesting to look through this little work.

On page sixteen, Observation XIX, is the case of "Mrs. Hall of Stratford, my wife" (Shakespeare's daughter), "being miserably tormented with the cholick, was cured as followeth:

R.—

Diaphen,

Diacatholic, each one ounce;

Pulv. Holland, two ounces;

Ol. Rut., one ounce.

Lactae q.s. Ft. clyster.

This, injected, gave two stools, yet the pain continued, being but little mitigated; therefore, I appointed to inject a pint of sack (a weak wine) made hot. This presently brought forth a great deal of wind and freed her from all pain. With one of these clysters I delivered the Earl of Northampton from a grievous cholick."

Michael Drayton was a contemporary and intimate associate of Shakespeare. His poetry, particularly his sonnets, is valued today. Observation XXII is as follows: "Mr. Drayton, an excellent poet, labouring of a Tertian, was cured by the following:

R.—

The Emetick Infusion, one ounce;

Syrup of Violets, a spoonful.

Mix them. This given, wrought very well both upward and downward.

"Observation XXXVI, Elizabeth Hall, my only daughter [Shakespeare's granddaughter] was vexed with tortura oris, or the convulsion of the mouth, and was happily cured as followeth (I first exhibited these pills):

R.—Pil Coch and Aurear, each one drachm.

Ft. Pil 10. She took five the first day, which gave her seven stools; the next day with the other five she had five stools." He then goes on recounting his daughter's case, and in conclusion says: "Thus was she delivered from death and deadly diseases, and was well for many years. To God be praised."

This little book gives us quaint reading, but we must not forget that all along in the development of medicine there are records the reading of which would make us smile.

In spite of this ancient style of Dr. Hall he was a scholar and a painstaking general practitioner. He was proficient in both Latin and French, and it is inferred that he also was quite a traveler.

This time of Shakespeare, the Elizabethan period, the last half of the sixteenth century and the opening years of the seventeenth, formed the seething years of an intellectual new birth. The world had not seen such intellectual activity since the days of Æschylus, Sophocles, and Euripides, four hundred years before the Christian era.

This day of Shakespeare witnessed the circumnavigation of the globe by Sir Francis Drake, the explorations of Henry Hudson, Martin Frobisher, Sir John Franklin, and William Baffin; the colonization by Sir Walter Raleigh, whose death occurred in 1618, two years after that of the poet. It was the time of Christopher Marlowe, Ben Jonson, and Beaumont and Fletcher, while John Milton, the poet, who ranks second only to our bard, was eight years old when Shakespeare died. It was also during Shakespeare's day that the world was given that ideal model of English, the King James translation of the Bible.

We of the medical profession should not fail to remember that the scientific students were as active as poets,

dramatists, and explorers; for while this is a Shakespearean tercentenary, 1616 was the year in which, in a course of lectures delivered in St. Bartholomew's Hospital in London, William Harvey first announced his discovery of the circulation of the blood.

The tercentenary of William Harvey's discovery would fully justify a far more general celebration than it is receiving.

In conclusion Dr. John Hall, the subject of our sketch, was not a great man. He held the position in his day that the leading practitioner in Pasadena, Long Beach, or Santa Monica hold today, a strong, busy, useful personality. The fact that his little book passed through three editions in twenty-five years, that the leading members of the profession spoke highly of him, and that Roman Catholic, High Churchman, and non-churchman employed him, although he was a staunch Puritan, give proof conclusive that he was a strong and forceful character and a credit to our profession.

1414 South Hope Street.

NEW YORK AND NEW ENGLAND ASSOCIATION OF RAILWAY SURGEONS.

The twenty-sixth annual session of the New York and New England Association of Railway Surgeons will be held at the Hotel McAlpin, New York City, on Wednesday, October 18, 1916. A very interesting and attractive program has been arranged. Dr. Wm. S. Bainbridge will deliver the "Address in Surgery," on the Cancer Problem. Railway surgeons, attorneys and officials and all members of the medical profession are cordially invited to attend.

DR. GEORGE CHAFFEE.

Corresponding Secretary.

Little Meadows, Pa.

DR. D. H. LAKE,

President,

Kingston, Pa.

AORTITIS SYPHILITICA.

BY DR. J. W. HELD, ANGLO-AMERICAN MEDICAL ASSOCIATION, BERLIN.

Aortitis syphilitica shows a characteristic pathological picture. The lesion is confined to the media, where fold-like elevations, between which contractions of fibrous tissue are seen. The contractions form distinct depressions which finally cause a thinning out of the wall of the aorta with the formation of aneurysm. These changes mostly spread to the aortic valves and sometimes also to the other ostii. The abdominal aorta is seldom, and according to some, never affected. The microscopical changes are also confined to the media, and they consist of red cell infiltration, granular tissue formation, and new blood vessels. In cases where arterio-sclerotic changes are associated with syphilitic changes diagnosis becomes difficult, and here a post-mortem Wassermann is a great aid.

Symptoms differ according to what part of the aorta is involved and also as to whether the aortic valve or coronary arteries are invaded. In cases where the arch of the aorta is diseased, symptoms are marked even early in the disease. They consist of a burning pain under the sternum which later becomes severe and radiates towards the left and sometimes both shoulders. Rapid exhaustion, dyspnea on slightest exertion, and markedly disturbed nights on account of pain are characteristic features. Attacks simulating angina pectoris, but differing from the latter, inasmuch as there is missing the apprehension of sudden death in the former, are not infrequent. Where the aortic valve is affected, all symptoms and signs of aortic insufficiency are present, with the exception that the cor bovinum is not present, and signs of the compensation are early and besides the diastolic murmur at the aortic region a systolic murmur due to roughening of the aorta is frequently heard.

Where the coronary arteries are involved the clinical picture of angina pectoris is pronounced, with the characteristic feature of the disease occurring at an early age. Careful percussion will not fail to redeem the large aorta and auscultation will mostly detect a ringing second aortic sound or a diastolic murmur blood pressure is usually high. The X-ray is of inestimable value in the diagnosis and much more so is the Wassermann reaction. As the disease is so frequently associated with tabes dorsalis, and dementia paralytica, we must carefully examine for the last named diseases in cases of aortitis syphilitica.

Prognosis. Restitutio ad integrum is out of question, but proper treatment can prolong life and make it comfortable for many years.

Treatment. Salvarsan in doses of 0.1 intravenously or Neosalvarsan 0.25 intravenously is to be given every fourth day until three or four doses are given. During this treatment patient is to stay in bed. After the course of Salvarsan Salicylate of Mercury in doses of 0.015 intramuscularly twice weekly, sixteen injections, Potassium iodide 0.5 t.i.d. of great service. The condition of the kidneys of the patient must be carefully watched, as uremia frequently terminates the disease.

Friedrichstr, 105.

NOTE.

As chairman of public health, California Federation of Women Clubs, L. A. Dist., Dr. Lulu H. Peters would like to communicate with any of our county medical physicians willing and able to help with lecture work before the Federated Clubs.

SIR VICTOR HORSLEY. Resumé of His Career.

BY CECIL E. REYNOLDS, M.R.C.S.*



SIR VICTOR HORSLEY.

Sir Victor Alexander Haden Horsley, the pioneer investigator of the functions of the brain and thyroid gland and eminent surgeon, has sacrificed his life for duty in the torrid tropics of the Persian Gulf whilst serving with the British forces. His contributions to science are as well known and valued in America as in Europe.

Sir Victor was born in 1857. He was the son of John Calcott Horsley, R.A., a painter of considerable note. His paternal grandfather was William Horsley, the composer, and his great uncle was another Royal Academician, Sir Augustus Calcott, the landscape painter. Many of his family were medical men, including Sir Seymour Haden, who was not only a distinguished physician but also invented a new process of etching, in which art

also he was noted. Sir Victor Horsley, himself a virile product of these ancestral combinations, exemplified the truth of the old saying that "Blood will tell," if it is kept clear, for he possessed the maximum of imagination, perseverance, scientific accuracy and artistic skill.

He was educated at University College and Hospital, London, and graduated M.B., B.S., in 1881, being the Scholar and Gold Medallist in Surgery, and in 1883 he took the F.R.C.S. Eng. In 1885 he was appointed to the Surgical Staff of University College Hospital, in 1887 became Professor of Pathology and in 1889 was elected Professor of Clinical Surgery in the above hospital.

From 1884 to 1890 he was also Professor Superintendent of the Brown Institution, when he carried out experimental investigations in the function of the brain and of the thyroid gland, being the first to prove the connection between the thyroid gland and myxoedema. His brain investigations were, of course, epoch making. In 1885 he was Secretary to the Royal Commission on hydrophobia and conducted further researches along the lines that Pasteur had mapped out. Corroborating Pasteur's findings, Sir Victor influenced legislation and completely stamped out rabies in Great Britain. In 1886 he was elected a Fellow of the Royal Society, an honor only conferred on those who have benefitted society by original research. In the same year he was appointed Surgeon to the National Hospital for Paralyzed and Epileptic and at once attracted notice by successfully operating for brain tumor. In 1890 he first grafted thyroid gland into the bodies of patients suffering from myxoedema with success; a re-

view on the subject from Horsley's pen appearing in Virchow's *Festschrift* in 1891. From then on appointments and honors came to him in abundance. To mention a few:—the Cameron Prize of Edinburgh for Therapeutics; the Fullerian Professorship of the Royal Institution; the Royal medal of the Royal Society in 1894; the Fothergillian medal of the Medical Society of London in 1896 and the Knighthood and "Commander of the Bath" in 1902 in recognition of his services with the Mediterranean expeditionary force.

He was the recipient of many honorary degrees and diplomas from American and foreign European learned societies. From France he received the Lannelongue Prize for originating the greatest advance in surgery during the preceding years, and was elected associate of the Academie de Medicine. He represented France at the funeral of Lord Lister. In Germany he was selected to address the German Society of Neurologists in 1910 on the Surgical vs. the Expectant Treatment of Intracranial Tumor. During all this time he quietly pursued his researches at University College and he was generally to be found in his laboratory at noon if any of us needed advice. In spite of the distorted viewpoint of the antivivisectionists, Horsley was kindness itself. He was extremely sensitive to the sufferings of others and very fond of animals.

The writer would frequently meet him at the Zoological Gardens on members' days, with his family, feeding the elephants with buns and the monkeys with nuts. Moreover, if ever a student incurred his censure, he never appeared to remember it afterwards, if that student were earnest in his endeavors to improve.

Major McCarnison truly writes: "His accessibility was one of his most lovable traits and for man or beast he was ever ready to exert his skill to the utmost," to which one might add that he

would on innumerable occasions set aside an hour in the evenings at his home to give personal advice to students and practitioners.

Sir Victor Horsley married in 1887 the daughter of Sir Frederick Bramwell, and his two sons are serving in the present war as officers in the Gordon Highlanders. He was always keenly interested in the medical welfare of the army and anxious to lend the government his aid in time of war, as in time of peace he entered the political field in order to fight the ravages of alcohol. He served with His Majesty's forces from the commencement of the present war, in Egypt and the Mediterranean. He visited all the beaches of Gallipoli in the task of medical organization and during the Senussi rising was continually employed in heavy consulting work for the army in Alexandria and the neighborhood.

Happening to hear that the need for medical organization was still more urgent in Mesopotamia, he at once, and with characteristic directness, volunteered for service there in March, 1916. He labored incessantly until July 15, when he was suddenly stricken at Amara with fever of 104°. Next day his temperature rose to 108° and he lapsed into coma, dying at 8:30 p.m. on July 16, presumably from heat stroke. To follow this partial recital of facts concerning a great descendant of a distinguished family with any personal opinions is to some extent superfluous, but a reference to the various notices written by those who were privileged to work under him indicates the degree to which he inspired his fellow-men.

Dr. Ross says: "Whether or not a thing should be done depended on one thing only: 'Was it right?' Never 'Was it expedient,' with Horsley."

Singleness of purpose and unflagging energy were seldom seen developed to such a pitch in any individual. His honesty was of cast steel quality and just as he went to Mesopotamia in his

last days so did he all things in a manner that seemed almost aggressive in its directness. He was the great apostle of scientific truth.

Sir William Osler writes: "Better than any man of his generation Victor Horsley upheld a great British tradition, for he combined the experimental physiologist and the practical surgeon in a degree unequaled since John Hunter. In his deft hands experiment reached a perfection not before known in the laboratory. To have recharted (with his friends Beevor Schafer Mott, Gotch, and Semon) the cerebral cortex was a brilliant achievement. A technique of such perfection was reached that the surgery of the laboratory was a decade ahead of the clinic. There was a mind, too, behind the hands—resolute, keen and fertile in suggestion. He had the true scientific spirit, open and free without secrets or seclusion, and a fraternal kindness that gave the lion's share of credit to others. What a pity that twenty-five years ago the medical organization of London had no abiding home in the shape of a physiological institute for a man of Horsley's genius!

He took over to a hospital career qualities that enabled him to give us within a few years three of the greatest sensations of our time. His paper on Brain Surgery in 1886 electrified the profession and with MacEwen's contemporaneous work put British surgery in the van in this field. Less dramatic, but perhaps more profound, was the impression made in the following year by the successful removal of tumors of the spinal cord. In this great war scores of lives have been saved by the application of his surgical lessons. In spite of the incessant demands of practice he managed to keep in daily touch with laboratory work and was rarely without a special research student. From personal experience I know how freely his time was

at the disposal of innumerable visitors who sought his clinics.

What demon drove a man of this type into the muddy pool of politics? A born reformer, he could not resist. Fearless, dogmatic and assertive, once in a contest no manna dropping words came from his tongue. A hard hitter and always with a fanatical conviction of the justice of his cause, what wonder that the world's coarse fingers could not always plumb the sincerity of his motives! Let us 'leave the heat of his faith to God's sole judgment, and the light of his good works to men's imitation.' One summer evening in 1878 at the house of Daniel Hack Tuke, I met two young students of University College, whose bright eyes held the light of high promise. One, Willie Tuke, was cut down at the outset of a brilliant career. The upward path of the other I followed from afar with an affectionate interest, and it was with no small measure of gratification that I saw Victor Horsley become the Greatest Hunterian Surgeon of his day."

Mr. Wilfrid Trotter has contributed a long resumé of Horsley's surgical work in the British Medical Journal, with his characteristic unemotional conciseness. He adds, however, the following personal note: "Horsley's easy simplicity, his charming sense of fun, his assumption of complete equality, won from his house surgeons and dressers a devotion too deep to be disturbed by the passing agitations of the operating theatre." In a personal letter to the writer, Mr. Trotter also says: "Isn't it horrible the world should have lost Horsley? The more I knew of him the greater did my respect and affection become. There is no one in the least able to carry on his work."

Perhaps not, but the writer is thankful to feel that the mantle of Horsley descended upon Wilfrid Trotter some time ago; and moreover that Horsley

felt it also for he has many times remarked to the writer upon Trotter's unique intellect and aptitude in his particular field of work.

The saddest feature of the whole affair is that Horsley's life was thrown away. No man of his age ought to have been allowed to go into the confines of the Persian Gulf unacclimatized as he was, and however great his ardour his friends should have saved him from the indiscriminating rule of thumb methods characteristic of war offices, and persuaded him to apply his genius and skill where they would have been equally useful and more zealously guarded. Those who knew Horsley never expected him to think of himself. It was the work with him and nothing but the work to be accomplished in the right way.

506 Exchange Bldg., Los Angeles.

PHILADELPHIA ACADEMY OF SURGERY.

**The Samuel D. Gross Prize Fifteen
Hundred Dollars.**

**Essays will be received in competition
for the prize until January 1st, 1920.**

The conditions annexed by the testator are that the prize "shall be awarded every five years to the writer of the best original essay, not exceeding one hundred and fifty printed pages, octavo, in length, illustrative of some subject in Surgical Pathology or Surgical Practice, founded upon original investigations, the candidates for the prize to be American citizens."

It is expressly stipulated that the competitor who receives the prize, shall publish his essay in book form, and that he shall deposit one copy of the work in the Samuel D. Gross Library of the Philadelphia Academy of Surgery, and that on the title page, it shall be stated that to the essay was awarded the Samuel D. Gross Prize of the Philadelphia Academy of Surgery.

The essays, which must be written by a single author in the English language,

should be sent to the "Trustees of the Samuel D. Gross Prize of the Philadelphia Academy of Surgery, care of the College of Physicians, 19 S. 22nd St., Philadelphia," on or before January 1, 1920.

Each essay must be typewritten, distinguished by a motto, and accompanied by a sealed envelope bearing the same motto, containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The Committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The Committee reserves the right to make no award if the essays submitted are not considered worthy of the prize.

William J. Taylor, M.D.,

John H. Jopson, M.D.,

Edward B. Hodge, M.D.,

Trustees.

Philadelphia, March 1st, 1916.

THE MULTIPLICITY OF WOMEN'S COMPLAINTS is known of all physicians who have to do with women in their general practice. The physicians know, if they do not, that a great many of these symptoms arise from the same underlying cause, namely, a derangement of the functional activities of the generative organs, which may register itself in amenorrhea, or in menorrhagia, or in dysmenorrhea, or what-not. What is needed is some remedy which will restore tone to the pelvic organs, and induce them to functionate normally. For many years Hayden's Viburnum Compound has enjoyed the reputation of accomplishing this desired result quickly, safely, and pleasantly. It consists of a skilfully combined series of remedies known to have a marked beneficial effect upon the uterus and its adnexia. Thousands of doctors throughout the country are using this established remedy, and testifying to its efficiency in this class of troubles.

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A MEDICAL, CLIMATOLOGICAL AND SOCIOLOGICAL MONTHLY MAGAZINE.

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EDITOR SOUTHERN CALIFORNIA PRACTITIONER,

Subscription Price, per annum, \$2.00. 500 Auditorium Building, Los Angeles, Cal.

EDITORIAL

DR. STIVERS AT THE HELM.

During September and October Dr. C. G. Stivers will occupy the editorial chair of this publication. Help him all you can. Don't argue. Don't stutter.

In the death of Dr. John B. Murphy, the medical profession not only of America but of the world, has suffered a great loss.

Dr. Murphy was a man of gigantic intellectual capacity, devoted to the highest ideals of surgery and medicine, and a man of untiring energy and determination.

In years past in attending his clinics in Chicago I have been impressed that he was working far beyond his physical capacity and it has surprised me that he has survived to the present time. At the end of his clinical hours I have been impressed with the fact that he was near the point of exhaustion, and have then seen him turn to calls which he considered it his duty to attend, and I think he never shirked a

duty; often forgetting his own physical condition in the interests of those demanding his services.

One incident that occurred in 1913 in London, has always been of interest to me. It was during the International Congress and in the surgical section. Dr. Murphy, Dr. Geo. Crile, Dr. Dudley of Chicago, and myself were sitting in the audience listening to a paper by Prof. Bastianelli of Rome on the subject of "Operative Work in Malignant Growths of the Colon." Sir Frederick Eve, of London, who opened the discussion, spoke of his own work in this line and quoted some statistics, proving that anastomoses of the small intestine with the colon had given much better results without than with the use of the Murphy button.

At the close of the discussion Sir Watson Cheyne, who was chairman of the section, noticing Dr. Murphy in the audience called upon him for some remarks. After complimenting the paper and bringing out the many good points

it contained, and commenting favorably upon the discussion by Sir Frederick Eve, Dr. Murphy said he was delighted with the remark that Sir Frederick had made concerning the use of the Murphy button in such anastomoses. He said the statistics tallied exactly with his own statistics of some ten years previous and that he supposed he had made it known to the world at that time that the Murphy button should never be used in making a union of the small intestine with the descending colon. The turn was such a beautiful one and so illustrative of the acumen of Dr. Murphy in discussions that it is here worth mentioning.

Dr. Murphy was not only an indefatigable worker who had acquired a profound knowledge of pathology that was always ready for expression, but he had that very great quality which so few teachers possess, namely, the abil-

ity to impart knowledge in a way that was most impressive. It is one thing for a man to have a perfect knowledge of his subject and quite another thing to be able to impart it understandingly to others and in a manner that forces home the subject at hand.

In the various clinics in this country and abroad that I have visited it has always seemed to me that I have found no one who had this peculiar ability to impart medical and surgical knowledge so readily as this beloved master.

The family mourns his loss, America and the world at large will feel the loss greatly. Throughout the country are thousands of homes that during the present and coming generation will testify to his ability, his kindness and his many deeds of heroism in the work that he was particularly fitted for.

GEO. L. COLE.

EDITORIAL NOTES

Lister died at eighty-five, his father at eighty-three and his paternal grandfather at ninety-three.

Dr. Albert W. Moore of Los Angeles is taking a professional and pleasure trip through Eastern States.

Dr. Thomas Powell died recently in Los Angeles. He was opposed to the germ theory of disease.

Dr. Caroline McQuiston was married to Mr. A. P. Leete on July 31, 1916, at the home of her mother in Pasadena.

The College of Physicians and Surgeons, University of Southern California, opened for the year on September 5th, with an augmented registration.

Dr. Olga and Lysle McNeile have returned from their very pleasant and extended trip through the east. The time was devoted to study, hospital visiting and sight-seeing.

Dr. Rex D. Duncan, who is devoting himself to Radium Therapy, is located in Suite 805, I. N. Van Nuys Building, Seventh and Spring Streets, Los Angeles.

Dr. Ethel Leonard accepts on September 1, 1916, a very pleasant position as laboratory diagnostician in the much enlarged and improved Milk Diet Sanitarium in Fernando.

Four-year-old Jane Samter, only child of Mr. and Mrs. Maurice L. Samter, 2576 Washington Street, is the first San Francisco victim of the child plague, infantile paralysis.

W. O. Henry, M.D., F.A.C.S., has returned from the east to resume his practice in Los Angeles. He is located in Suite 926, Marsh-Strong Building, at Ninth and Main Streets, and is specializing in Gynecology and Surgery.

Dr. I. B. Gregory, for years a prominent physician of Ontario, has been obliged on account of ill health to retire. She leaves Dr. S. E. Ballard, formerly of Waco, Texas, in charge. We hope Dr. Gregory will soon return to her health and practice.

The typhoid carrier, a woman who recently bore the disease about with her and infected at least twenty-three persons, was located by Professor James Gordon Cummings, assistant clinical specialist in protective medicine and hygiene at the State University. Her identity is not revealed.

For Sale—New fireproof general hospital in prosperous Southern California town near Los Angeles. Capacity, 35 patients. Very complete new building, never occupied. Great bargain and favorable terms to right party. Address Secretary, P. O. Box 476, Los Angeles, California.

Reprints received, "Tonsillectomy, a new method of tonsil eradication," by A. M. McWhinnie, M.D., Seattle. "The Relation of the Thyroid Gland to Epilepsy," and "Connecting Links Between Endocrinology (The Internal Secretions) and Otorhinology," by Henry R. Harrower, M.D., Los Angeles, Cal.

The State Board of Health has declared San Mateo County as "plague-infected territory," plague-infected squirrels having been found recently in that country. This action on the part of the State Board makes it possible for the State and Federal authorities to start a campaign for the extermination of the rodents.

Dr. Sandford Whiting, formerly of Portland, Or., has located in Los Angeles, in the Citizens National Bank Bldg., where his practice will be limited to General Surgery. Dr. Whiting had practiced surgery in Portland for

the past twenty years and was captain in the Oregon regiment, U. S. Volunteers, during the Spanish-American War, and saw service in the Philippines.

During the month of June there were two deaths from typhoid fever in the city of Los Angeles. A mortality of two from typhoid in a population of over five hundred thousand is certainly very light for a summer month. During the same month there were nine deaths from whooping cough.

Orange Juice—At a recent meeting of the New York Academy of Medicine, Dr. Alfred Hess reported that a mild grade of scurvy developed in a group of infants artificially fed on Pasteurized milk and barley water, while a control group to whose diet orange juice was added, but who received the same milk modifications as the first group remained entirely free from scurvy. Among the infants in the first group the scorbutic symptoms promptly disappeared on administration of orange juice.

On account of the statements made by the Journal of the American Medical Association concerning Cardni, a proprietary article manufactured by the Chattanooga Medicine Company, made, we think, in April, 1914, a suit for libel was filed for \$100,000 damages in the federal court. Also on account of statements alleged to be derogatory to the personal character of Mr. John A. Patton, president of the Chattanooga Medicine Company, a suit for libel was at the same time begun by him personally. The trial was held before the federal court in Chicago, beginning in April of this year and continuing through fifty-seven days.

During the progress of the trial Mr. Patton died; by that automatically the personal suit for libel was abated. The trial came to its close June 17, and the jury retired. On the first ballot, eight to four of the jurors voted to inflict

upon the Journal the full penalty of \$50,000 with costs. Seventeen other ballots showed the same result. After an all-night session on the fifth day, a conference was asked for with Judge Landis.

Judge Landis having informed the jury that the size of the penalty was a matter in the hands of the jury, the jurors retired and in twenty minutes, on the sixth day, brought in the verdict of guilty, but assessing the damage to the company at one cent.

ONE BOOK AND A WHOLE LIBRARY.

Manual of Vital Function Testing Methods and Their Interpretation.
By Wilfred M. Barton, M.D., Attending Physician to Washington Asylum Hospital, Professor of Georgetown University.

Have you in your library one book that gives at a glance every known functional test of the vital organs? Do you refer to the heart in one volume, the liver in another, and so on through a great many books each devoted to this special subject?

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in the country. The vast amount of material contained in its pages makes it as valuable to have as any ten books in your library.

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500 Auditorium Bldg., Los Angeles.

BOOK REVIEWS

STUDIES IN IMMUNIZATION AGAINST TUBERCULOSIS. By Karl Von Ruck, M.D., and Silvio Von Ruck. Published by Paul B. Hoeber, New York, 1916. Price \$4.00.

In the preface the Co-authors state that this volume of over 400 pages is intended to be used by general practitioners. The subject of the immunization against tuberculosis is presented in as simple a manner as possible. It

is held, "That the far-reaching therapeutic nihilism which still prevails and which has let it become almost a dogma that tuberculosis must be treated with 'Air, water, rest and good food' and that active remedial measures are of comparatively slight value or negligible is to be deprecated if it excludes the administration of drugs or of specific remedies that may be of

benefit to the patients." The Authors say their method of immunization was published only after it had been proved effective and free from danger in a large number of individuals.

The Von Rucks made many experiments with infected and non-infected Guinea pigs, using both before and after infection watery extract of tubercle bacilli but they confess their results were not conclusive, but in 1908 they employed "a whole vaccine in solution of the tubercle bacillus" and claim to be the first to act upon the recognition of the fact that "all active substances of the tubercle bacillus including the bacillary fats are required." Specific directions for the administration of vaccine for both prophylactic and curative effects in tuberculosis are given and X-ray examinations are advised. The general management of patients is discussed. The results of exhaustive research into the subject of immunization is given, Guinea pigs come in for a share in the study. A good index adds to the value of this most interesting scientific study of tuberculosis.

THE TREATMENT OF INFANTILE PARALYSIS. By Robt. W. Lovett, M.D., Boston, Professor of Orthopedic Surgery, Harvard Medical School, etc.

The great prevalence of infantile paralysis in America since 1907 has not only directed the attention of the medical profession to the disease in a very practical way, but has led to a rapid advance in our knowledge of the affection and of its treatment.

Text-books on the subject are wanting and the necessity of correlating the known facts has induced this well-qualified author to write this book, which he says is concerned wholly with treatment except for a short introductory chapter dealing with other aspects of the disease in their bearing on treatment.

The pathology, etiology and transmission have not kept pace with the

treatment in which surgical operative procedures and muscle training all in the domain of the orthopedist, have done much to relieve the horrible distortions and paralysis consequent to this widely discussed malady. The subject of muscle training receives exceptionally full treatment. The book is from the excellent house of P. Blakiston's Sons & Co., Philadelphia.

THE PRACTICE OF OBSTETRICS. Designed for the use of Students and Practitioners of Medicine. By J. Clifton Edgar, Professor of Clinical Midwifery in the Cornell University Medical College, etc. Fifth Edition, revised. Twenty-second thousand, with 1316 illustrations, including five colored plates and 34 figures printed in colors. P. Blakiston's Sons & Co., 1012 Walnut Street, Philadelphia.

In this fifth edition, new matter will be found in the articles on Painless Labor and Twilight Sleep, Pituitary Extract in Uterine Inertia, and the Artificial Feeding of Infants.

This is a recognized standard textbook written by a man who has had abundant experience in clinical midwifery and in its teaching. The text is clear and the illustrations excellent. A valuable system of card indexing is suggested and explained—and a full general index to the contents adds to the value of this volume. Price \$6.00.

PHYSICS AND CHEMISTRY FOR NURSES. By Amy Elizabeth Pope, author of "Quiz Book of Nursing," "Anatomy and Physiology for Nurses," etc. Published by G. P. Putnam's Sons, New York and London.

The first part of this very practical book is devoted to Physics and Chemistry. A very interesting and valuable chapter to students of economics is that on the "Chemistry of Cleaning." Chapter on textiles, chemical constituents of foods, nutritive value of foods, and on the spoiling and adulteration and preservation of food, milk testing, etc., are full of valuable information. Sufficient insight into the processes of absorption and metabolism and the analysis of urine may be obtained by

the nurse who desires above all things to cooperate with physicians in either private or hospital practice. A well arranged index adds to the value of this most useful volume for reference and study.

A MANUAL OF OTOLOGY. For Students and Practitioners. By Charles Edwin Perkins, M.D., F.A.C.S., Professor of Clinical Otology in New York University and Bellevue Hospital Medical College; Associate Aural Surgeon to St. Luke's Hospital; Assistant Aural Surgeon, New York Eye and Ear Infirmary; Fellow, American Otological Society, New York Otological Society, New York Academy of Medicine, etc. 12 mo., 445 pages, with 120 engravings. Cloth, \$3.00, net.

This handy size, up to the minute volume represents the most advanced ideas on the subject written by a man whose long experience as both specialist and teacher gives him an authority. The subject is clearly set forth in such a manner as to be readily understood by general practitioners and students and specialists.

The cuts are from Gray's Anatomy and the text is illustrated also by some excellent drawings and half tones. In the vexed subject of Otitis media purulent, vaccines are dismissed with the statement that their use has been reported to be of use in some cases but the author's experience does not encourage him to expect much from them. The book is from the excellent press of Lea & Febiger, New York.

INFECTIONS OF THE HAND. A Guide to the Surgical Treatment of Acute and Chronic Suppurative Processes in the Fingers, Hand and Forearm. By Allen B. Kanavel, M.D., Assistant Professor of Surgery, Northwestern University Medical School; Attending Surgeon, Wesley and Cook County Hospitals, Chicago. New (third) edition, thoroughly revised. Octavo, 498 pages, with 161 illustrations. Cloth, \$3.75, net. Lea & Febiger, Publishers, Philadelphia and New York, 1916.

The importance of this work to all surgeons is demonstrated by the fact that it has passed so quickly through two large editions. The urgent demand for a third has given the author an op-

portunity to enhance the value of his monograph by a thorough revision and by the addition of two chapters: the first upon the "Relation of Acute Infective Processes to Industrial Pursuits," and the second upon "Plastic Procedures Instituted for the Correction of Deformities." The entire work has been thoroughly revised and enlarged, and a number of new illustrations have been added.

The enormous economic significance of infections of the hand is coming to be universally recognized and there is probably no other class of cases where malpractice is more common or unfortunate results of treatment more frequent. The subject of this book is, therefore, of the greatest importance to every surgeon and general practitioner. The surgeon who does casualty work or has charge of industrial accidents will find the work invaluable, and many deformed hands might be prevented if every practitioner were familiar with the importance of this subject and with the complete manner in which this book handles it.

BOOKS RECEIVED.

THE CLINICS OF JOHN B. MURPHY, M.D. At Mercy Hospital, Chicago. Edited by P. G. Skillern, Jr., M.D., of Philadelphia. August, 1916. W. B. Saunders Company.

Transactions of the American Association of Obstetricians and Gynecologists. Vol. XXVIII for the year 1915.

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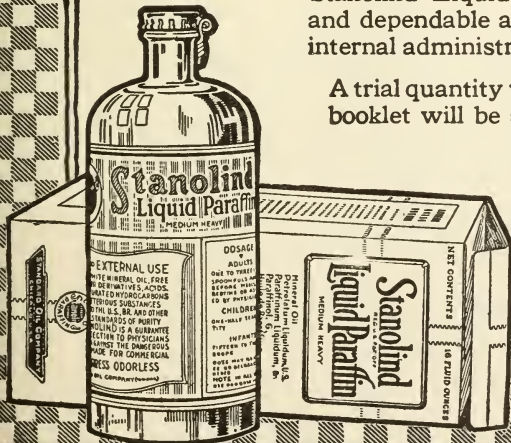
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31b



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Congress has recently made an appropriation for thirty-three additional Assistant Surgeons in the United States Public Health Service. These officers are commissioned by the President, and confirmed by the Senate. The tenure of office is permanent, and successful candidates will immediately receive their commissions.

After four years' service, assistant surgeons are entitled to examination for promotion to the grade of passed assistant surgeon. Passed assistant surgeons after twelve years' service are entitled to examination for promotion to the grade of surgeon.

Assistant surgeons receive \$2000, passed assistant surgeons \$2400, surgeons \$3000, senior surgeons \$3500, and assistant surgeon-generals \$4000 a year. When quarters are not provided, commutation at the rate of \$30, \$40 and \$50 a month, according to the grade, is allowed.

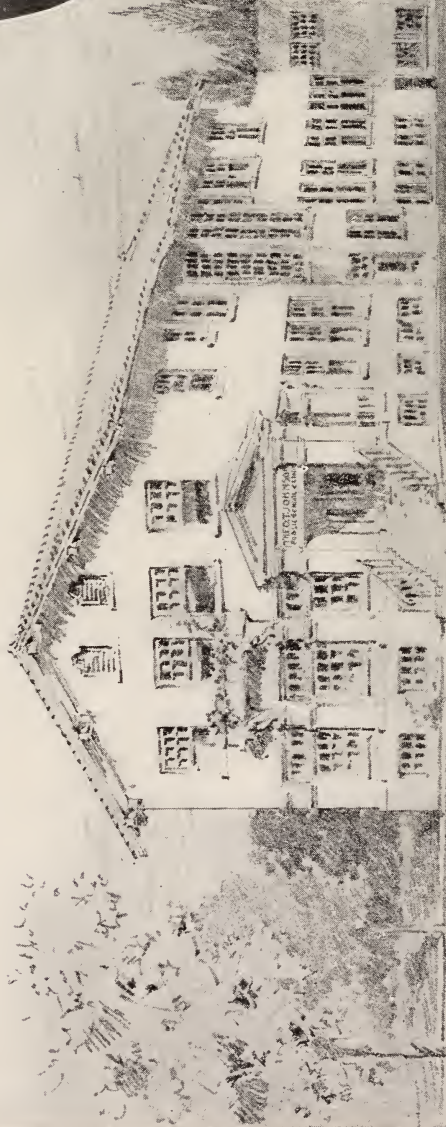
All grades receive longevity pay, 10 per cent in addition to the regular salary for every five years up to 40 per cent after twenty years' service.

Examinations will be held every month or so in various cities, for the convenience of candidates taking the examination. Further information will be furnished by addressing the Surgeon-General, United States Public Health Service, Washington, D. C.

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THE DIAGNOSIS OF THE INTERNAL SECRETORY DISEASES.

BY HENRY R. HARROWER, M.D., F.R.S.N. (LOND.), LOS ANGELES, CAL.

VI.

The Disorders of the Pituitary Body.

The study of the various phases of endocrinology seems to have advanced in waves; and our knowledge of the clinical and physiological relations of the hypophysis or pituitary body is a good example of this. Thirty years ago quite an interest was aroused in this remarkable gland by the publication of Marie's classical study of the pathology of acromegaly and his correlation with it of disease of the pituitary gland. Nearly ten years later—in 1894—a greater wave of enthusiasm and interest was launched by Sir Edward A. Schaefer who made the discovery that the pituitary was a gland of internal secretion. Numerous investigations were initiated by this report, many of which have added materially to our knowledge of this subject.

The third and greatest wave of all must be connected with the name of Harvey Cushing, and this has brought us to the present high tide of knowledge of the subject, for, thanks to the

results of the years which Cushing has spent in investigating pituitary disorders, the profession is better able to realize the comparative frequency of affections of this gland.

Cushing's Monograph, "The Pituitary Body and its Disorders" (1912) has been called the most complete and useful monograph in English; and the numerous publications of reports of his work and that of his associates include the major part of our present knowledge on this subject.

Physiological Considerations.

An appreciation of the essentials of the physiology of this gland, its interrelation with the other endocrine organs, and its influence upon the activities of the body, will enable us to detect the several results of functional pituitary dyscrasia during their early stages, before such obvious and serious changes as those present in acromegaly have established themselves.

It must be recalled that structurally the pituitary gland is divided into three parts: The largest anterior lobe being a typical glandular structure; the much smaller posterior lobe having the histological appearance of nervous tissue, while the very small connecting portion, usually called by its Latin name "pars intermedia", is made up of a mixture of both kinds of these cells. Each of these portions produces one or more chemical substances or hormones, the function of which are not all fully understood. Without going into detail, it may be stated that the anterior lobe produces a hormone which regulates the growth of the body. This was isolated recently by T. Brailsford Robertson of the University of California, and has been called by him "tethelin." In both physiology and organotherapy this substance promotes growth, especially that of bone and connective tissue; and it is anticipated that many useful advances in organotherapy will follow the clinical-experimental study of preparations derived from the anterior lobe of the pituitary.

From the posterior lobe there is secreted, presumably directly into the cerebro-spinal canal, a series of hormones which play an important part in the control of metabolism, especially that of the carbohydrates. They also influence in some subtle way the sympathetic nervous system quite similarly to the chromaffin hormone from the adrenals. Much clinical use has been made of the extract of the posterior lobe, and it undoubtedly exerts a very wonderful pharmacological influence upon unstriated muscle and particularly upon the uterus in labor. A diuretic hormone of considerable activity is also produced in this gland, some saying that it arises in the pars intermedia and others in the posterior lobe.

The pituitary body as a whole is very intimately connected with sex development as we shall shortly see; and is able to assist the thyroid and

gonads vicariously when this becomes necessary. These complex relationships complicate the study of the subject, and it might just as well be stated right here that it is not a simple task accurately to differentiate between the results of deficiencies of these endocrine glands, for their relations are so intimate that it is quite impossible for one to be affected without some chemical reflex influence being brought about in the work of most or all of the others; and as these glands seem to exert a compensatory influence upon the work of those glands with which they are correlated, it is often difficult to determine the original gland at fault in a given case, and unless this is done, suitable treatment, organotherapeutic or otherwise, may be impossible.

We have just noted that there is a great functional difference between the parts of the pituitary. Like a number of other endocrine organs it is a dual one, with differing structure and physiological powers; and it is possible that clinical manifestations due to affections of one lobe may differ very materially from those due to disturbances of the other. An attempt to facilitate a differentiation between the disorders of the two lobes will follow the consideration of disease of the whole gland.

Dyspituitarism.

When disorders of the pituitary gland are the result of tumors, cysts or intracellular dyscrasia, there may be varying secretory changes. On the one hand pressure due to the growth may prevent the normal secretory activity, while, on the other, the enlargement may be a pure hyperplasia with markedly increased function until the limitations of the sella turcica—the bony cup above the sphenoid bone in which the pituitary rests—cause a secondary hypofunction. Such cases are termed dyspituitarie, since varying results are produced. In fact many

individuals suffering from pituitary excess have at the same time well defined evidences of pituitary insufficiency, secondary to the original trouble.

Dyspituitarism, then, is pituitary secretory dyscrasia and may include the pure hypo- and hyper-function and all grades between them and combinations of them. By careful study it is often possible to decide which disturbance is predominant and also which is the original disorder. A diagnosis of "dyspituitarism" is good; but to qualify this and go further into the genesis of the disorder, is much better.

Pituitary Insufficiency.

With the fundamentals previously outlined in mind, we can expect marked changes in the metabolism as a result of insufficient activity of the pituitary gland. The most common result of insufficient function—hypopituitarism—is an undue increase in the deposit of fat which may later become a serious obesity, a condition which is probably due to the marked increase in the tolerance for carbohydrates usually found in hypopituitarism,* and the abnormal desire for food and especially for sweets with which this is quite often associated. It is not uncommon to find patients in this class eating ravenously with appetites far beyond the usual.

The cellular activities are generally reduced and the temperature is subnormal, movements slow and somnolence is a prominent symptom. Cushing and his associates have remarked that hibernation in certain animals seems to

be a physiological hypopituitarism. Lassitude, torpidity and drowsiness is often the first appreciated symptom. (Some months ago I saw a case with Dr. Roblee at Riverside, who would fall asleep during meals or in the middle of a sentence; and who, by the way, improved very much under pituitary medication.) Sleep is not always refreshing and tiredness is a usual complaint.

This reduced oxidation is probably due in part to an associated thyroid insufficiency. The urinary solids are reduced, but the amount of urine is often increased; and it is now believed that the majority of those suffering from extreme polyuria, or diabetes insipidus, really have a form of pituitary disease. According to Motzfeldt and others the lesion is in the posterior lobe, and the functional changes are on the side of hyposecretion.

There are retrogressive changes in the sex organs and functions. The syndrome described by Froehlich and Bartels—the so-called "dystrophia adiposogenitalis"—is due to hypopituitarism, the adiposity being marked and the sex-changes characteristic.

The age at which these conditions assert themselves naturally causes variations in the manifestations. When pituitary insufficiency is present in childhood or early youth, the developmental changes are more marked. The stature is small and skeletal growth is stunted. Genu valgum is quite common. The fingers are frequently tapered, and acromieria, i.e. unusually small hands and feet, has been noted by Timme, though this is rare compared with the correspondingly opposite (acromegaly) in the opposite condition. The epiphyses may remain ununited and, parenthetically, it is well in cases of reduced stature to have roentgen pictures made of a hand, so that if defective epiphysal growth is present, there is hope for comparatively successful results from suitable organotherapy.

*A urinary test for dyspituitarism is thus made possible. The high tolerance for sugar is usual in hypopituitarism. This may be easily demonstrated by giving measured, increasing amounts of sugar or, preferably, levulose, and noting how much may be taken without glycosuria. Often as much as 250 grams can be eaten (Cushing reports a case in which 450 grams was taken) without a trace of glucose in the urine passed during the next few hours thereafter. On the other hand in the opposite secretory condition—hyperpituitarism—there is a very low sugar tolerance, and not infrequently there may be glycosuria.

On the other hand, in dwarfs showing fully united epiphyses there is little hope that the most effective therapeutic measures will increase the stature.

Temperamentally hypopituitarie children are dull, apathetic, backward in their studies and easily discouraged. They often have difficulties with their playmates and lack both self-reliance and self-control.

The abnormalities of sex development are among the most typical results of pituitary insufficiency. The external genitals are small, the pubertal growth of hair is sparse or absent. There may be either cryptorchidism or infantile uterus with impotence or amenorrhea. The menses appear late or not at all, and if amenorrhea is not complete, the flow is scanty and irregular. The breasts often become extremely large due both to the adiposity usually present and to the reduced gonad activity. A peculiar and quite constant finding is a tendency to development which simulates that of the opposite sex, especially in the male, in whom the pubic hair is straight and the contour of the hips and chest quite female in type.

The head is often small and the face unintelligent, and the distance between the eyes narrowed. The teeth are usually malformed and broad. The skin is dry and soft, and compared with the dry, rough skin of hypothyroidism, is quite smooth to the touch. Perspiration is much reduced, even in hot weather and during exertion.

When hypopituitarism is acquired after maturity it is often the result of syphilis, and the developmental changes just enumerated are not present. Here, however, there is anaphrodisia and sexual atrophy, obesity which may be extreme with difficulty in locomotion and work, with a natural tendency to laziness and lethargy which further increases the asthenia and deposition of fat. Occasionally the fatty deposits

are painful on pressure and are very similar to Dercum's disease or adiposis dolorosa, a condition which is probably of both pituitary and thyroid origin. This adiposity causes difficulties with the heart and breathing and edema may supervene due to fatty pericardial involvement.

Asthenia is the rule, irrespective of the extent of the obesity, and the unstriated muscles seem to be affected equally with the voluntary muscles, hence constipation is common and the bladder walls may be unduly weak with incontinence. The heart action is weak and the pulse slow and of reduced volume. The blood pressure is low ranging from 100 mm. Hg. to as low as 50 mm. or less. The circulation is poor, the extremities are cold and sometimes edematous late in the day, and occasionally the skin exhibits the mottled appearance referred to in the previous chapter.

Several authorities have noticed epilepsy as an accompaniment of hypopituitarism. Just what is the relationship we have yet to learn, but several writers, including Cushing, have remarked that pituitary feeding caused a decided benefit to the epileptic manifestations as well as those which are more generally recognized as of pituitary origin.

Hyperpituitarism.

The start toward our present knowledge of the conditions associated with pituitary excess (hypertrophy and secretory activity) was made in the report of several cases in 1886 by Pierre Marie. He called the syndrome "acromegalia" because of the usually large hands and feet which were a prominent part of the clinical syndrome. A comparison of the manifestations of increased pituitary secretion would be expected to show diametrically opposite findings to many of the hypopituitarie conditions above. For example, children with hyperpitu-

itarism are large for their age, tall and bony framed. Their eyes are wide apart, the face is broad, the cheeks prominent and the jaw square and large. The condition of the facial bones is generally called prognathism. The teeth are many times large, broad and irregularly spaced.

Such individuals have large hands and feet, with long fingers and toes and an unusually early epiphyseal union. The hair is usually profuse, exhibits a tendency to grow low on the forehead, well up on the abdomen and, occasionally, hypertrichosis is present. The axillary and pubic hair comes unusually early and is always excessive. The skin is thick, harsh and sometimes puffy. The sweat glands are usually active.

The sexual development is excessive and in early cases precocity is to be expected and sexual irritability marked. The sympathetic system is well developed and highly sensitive. Hyperpituitarie individuals are often bright and keen and very excitable, though they lack the power of concentration and are indecisive. Temperamentally they are often irritable, distrustful, petulant and "difficult." They do not sleep well and insomnia is progressive as the glandular hypertrophy causes the local symptoms which will be referred to shortly.

The metabolism is plus and much accumulation of fat is rare. There may be a slight increase in the temperature, and the urinary solids are often increased. The tolerance to carbohydrates is reduced and the "carbohydrate tolerance test" is positive with 25 or 50 grams of sugar and not infrequently glycosuria is one of the symptoms of hyperpituitarism.

The pulse rate is occasionally increased though not very rapid; but the blood pressure may be high, ranging from 150 to 180 or more.

A word or two about the relation of gigantism to acromegaly. Of course

both these conditions are the result of hyperpituitarism; but in the former instance the dystrophy has commenced before ossification of the bones has taken place with a resultant increase in length principally. In acromegaly, i.e., hyperpituitarism after full development, the bones changes lean to thickness, hence the prognathism, protruding forehead and "heavy" facies, and the kyphotic spine not uncommonly seen.

Neighborhood Symptoms.

When the secretory disturbances of the pituitary are coupled with hypertrophic changes, a series of localized symptoms are caused which are of a wholly distinct character from those due to chemical changes,—are the pressure or neighborhood symptoms. These are ultimate results and are practically always accompanied by changes in the size and conformation of the sella turcica which can be seen and even measured by roentgenography.

Unfortunately these pressure symptoms are often the first indication that we have dyspituitarism to contend with, and they are practically only seen in advanced cases. Under such circumstances we can expect to find supplementary evidence of the cause of the trouble by looking for the systemic chemical changes of pituitary origin. These have already been enumerated. These localized symptoms are often so serious as to call for cerebral decompression and curative treatment is practically hopeless; while the general metabolic disturbances previously mentioned often may be favorably affected by persistent organotherapy.

To quote a statement from Cushing: "It is particularly important that we should learn to recognize these clinical expressions of hypophysial disorder in the absence of brain tumor symptoms or radioscopic enlargement of the pituitary fossa, in the same way that it is important for us to recognize thyroid disorders unaccompanied by gross evi-

dence of change in the configuration of the gland.''

Neighborhood symptoms may be roughly divided into two classes: Immediate (local) and intracranial (general) pressure effects. In the former we look for the results of pressure on the structures in contact with the mass, while in the latter, those found in any brain tumor—due to the increased intracranial pressure.

Among the former symptoms are well marked eye symptoms such as bitemporal hemianopsia (blindness of the outer temporal fields of vision) due to pressure on the optic chiasma. This usually first affects color only and later form. In more advanced cases, when the tumor extends beyond the sellar edges, squint results, due either to pressure on the sixth cranial nerve (internal strabismus) or the third cranial nerve (external strabismus). As a result of still more extensive involvement, there may be pressure on the crura cerebri and disturbances of gait with a positive Babinski sign. Certain epileptoid attacks, the so-called "uncinate fits" are occasionally seen and are probably due to pressure upon the uncinate gyrus. The relationship of epilepsy and pituitary disease is interesting and bids fair to offer a part of the solution of this problem.

Before the last of these pressure symptoms have been caused, general intracranial symptoms will have supervened. These consist chiefly of a severe intractable headache, paroxysmal in character and often affecting both temples, with vertigo, vomiting (often of the projectile type) and failing vision with later choked disc (papilloedema) and progressive destruction of the visual fields and ultimate optic atrophy.

Differentiating the Lobes Involved.

It is rare that we find dyspituitarism of a single lobe, though it is possible. It is not unusual, however, to find pre-

dominating symptoms indicating that the principal trouble is in one of the lobes. If we bear in mind the varying physiological activities of the different portions of the hypophysis we will expect to find anterior lobe disorders more frequently accompanied by changes in growth and skeletal development. We have seen that with hypersecretion early the result is gigantism, whereas later in life acromegaly is the result. On the other hand, hyposecretion retards growth and if it comes early the result is infantilism, while later it brings about retrogressive changes in the sex organs and manifestations.

Dystrophies of posterior lobe origin are quite different, since they account for the metabolic changes which cause the adiposity and increased carbohydrate tolerance found in hypopituitarism, while the excessive secretory activity of the posterior lobe produces a relative carbohydrate intolerance with glycosuria and increased metabolism and loss of weight.

Commonly both lobes are affected simultaneously, though the effects of one lobe may be more prominent and may change at different stages of the disease. Froehlich's syndrome, for instance, is evidently due to a secretory deficiency of the whole gland.

The Cause of Pituitary Affections.

Etiology is often of great service in making a therapeutically useful diagnosis. In the estimation of the writer syphilis is the chief cause of dyspituitarism, and while heredity is an evident factor, syphilis in parents and grandparents may have left an intangible susceptibility. The Wassermann test is very useful here.

New growths of the hypophysis, other than gummata, are common etiological factors the causes of which are still altogether unknown. Early organic changes in the bony pituitary fossa may restrict the proper development of

the growing gland. Brain tumors, either adjacent to the pituitary or remote from it, may cause dyspituitarism by increasing the intracranial pressure and the pituitary symptoms may entirely disappear following decompression.

It has also been suggested that as the posterior lobe is supposed to secrete into the cerebro-spinal canal, changes in the intraspinal pressure may cause pituitary disorder. The present epidemic of poliomyelitis in New York

City should offer some proof of this position, for if this is true, there should be a moderately large percentage of pituitary disorders follow in the hundreds marked by this disease; for we know that poliomyelitis is often accompanied by increased intraspinal pressure and that the relief of this tension causes a favorable effect on some of the symptoms.

715 Baker-Detwiler Building.

Next month, "Disturbances of the Thymus."

THE ROENTGEN RAY AS AN AID IN THE DIAGNOSIS OF GASTRIC CANCER AND ULCER.*

BY R. D. CARMAN, M.D., MAYO CLINIC, ROCHESTER, MINNESOTA.

The author gives a brief description of the routine radiologic examination of the digestive tract in the Mayo Clinic. He says:

"After the observer becomes familiar with his technic, has followed a large mass of material to operation and acquired confidence through confirmation of his diagnoses, he will find that prolonged examinations are neither necessary nor desirable."

"The Roentgen diagnosis of gastric lesions is based on departures from the normal form, tonus, position, motility, capacity, mobility, contour and peristalsis of the stomach, together with certain extraordinary phenomena, such as filling defects, incisuræ and diverticula."

The radiologic signs of cancer and ulcer of the stomach, respectively, are arranged in the order of their relative importance as follows:

Cancer.

"1. Filling defects. The filling defect is a sign of cardinal import and practically indispensable in the Roentgen-ray diagnosis of carcinoma. It is occasioned by the projection of the tumor-mass into the lumen of the stom-

ach, and when filled with bismuth the visualized contour of the gastric lumen shows a corresponding irregularity. True filling defects must be carefully differentiated from indentations of the wall of the stomach by a gas-filled colon, by adjacent extrinsic tumors; notably those of the liver, spleen, colon and mesentery and by spasm.

"2. Altered pyloric function. (a) Gaping of the pylorus. (b) Obstruction of the pylorus. Alteration of the pyloric function is an almost invariable accompaniment of gastric carcinoma, and may reveal itself in either of two quite opposite ways, namely, free and continuous patency, or marked obstruction.

"3. Advanced position of the six-hour meal.

"4. Absence of peristalsis from involved areas of the wall of the stomach. The interruption of peristaltic waves by carcinomatous infiltrations is important. A wave will progress to the affected area, skip it and take up its course beyond.

"5. Diminished mobility; loss of flexibility. Aside from diminished mobility en masse there may also be a

*Abstract of paper read before the Indiana State Medical Association.

notable loss of flexibility of the wall of the stomach, such that ordinary palpation has little effect on its contour.

“6. Diminution in size of the stomach.

“7. Antiperistalsis.

“With reasonable care and a decent regard for the clinical facts, the Roentgen-ray findings will not only markedly enhance the percentage of correct diagnoses of cancer, but will also often furnish valuable information as to the advisability of operative intervention. For example, extensive involvement of the cardia, or of the media and cardia, renders surgical measures hopeless, while pyloric carcinoma offers a better prospect for surgical intervention, especially if there be no metastasis.”

Ulcer.

“1. Visualization of the bismuth-filled crater of a callous ulcer (the nischen symptom). A bud-like projection from the contour of the bismuth-filled stomach, corresponding to the crater of a callous ulcer, is a definite and valuable sign.

“2. The diverticulum of perforating ulcer. The diverticulum of perforating ulcer is quite as characteristic. The perforation may be anterior into the liver or posterior into the pancreas. Organic hour-glass contraction of the stomach usually, but not invariably, accompanies diverticulum.

“3. The incisura. The incisura is an indentation of the greater curvature, usually in the vertical portion of the stomach, pars cardiaca or pars media, of varying width and depth. Its production is believed to be due to the irritation of the ulcer causing a spastic contraction of the circular muscle fibers in its plane, perhaps in some cases also due to infiltration and stiffening of these fibers. A true incisura is distinguishable from a peristaltic wave, not only by its depth, which is commonly greater than that of a peristaltic contraction, but also by the fact

that it does not move pylorusward. It persists in spite of vigorous palpation and is not effaced after the administration of belladonna to the patient.

“Signs which are not determinative but merely suggestive of ulcer include:

“1. Acute fish-hook form of the stomach with displacement to the left and down.

“2. Delayed opening of the pylorus.

“3. Localized pressure-tender point on the lesser curvature.

“4. Residue in the stomach after six hours.

“5. Lessened mobility.

“6. Settling of the bismuth to the lower pole of the stomach, such as is seen in hypotonicity or atony.”

In conclusion the author states: “The relative value of those signs, singly or in groups, can be learned only by experience. Nor should the diagnosis rest on them alone. The Roentgen-ray simply furnishes valuable contributory evidence as to the presence and nature of gastric lesions—so valuable that whenever available it should be routinely employed—but the final judgment should take into account all the evidence of every sort.

“Hence, the radiologist should be not only a radiographer but a clinician to the utmost of his ability, study his cases from the clinical side, follow them to the operating table, and take his rightful share of responsibility.

“The radiology of gastric lesions is still young, and with enthusiasm in the work and conservatism in adjudging the results, it will take still higher rank among diagnostic measures.”

NOTE.

As chairman of public health, California Federation of Women Clubs, L. A. Dist., Dr. Luht H. Peters would like to communicate with any of our county medical physicians willing and able to help with lecture work before the Federated Clubs.

SOUTHERN CALIFORNIA PRACTITIONER.

A MEDICAL, CLIMATOLOGICAL AND SOCIOLOGICAL MONTHLY MAGAZINE.

This journal endeavors to mirror the progress of the profession of California and Arizona.

Established in 1886 by Walter Lindley, M.D., LL.D.
DR. GEORGE E. MALSBARY, Editor and Publisher.

Associate Editors,

Dr. Walter Lindley, Dr. W. W. Watkins, Dr. Elbert Wing, Dr. Ross Moore, Dr. George L. Cole, Dr. Cecil E. Reynolds, Dr. William A. Edwards, Dr. Andrew W. Morton, Dr. H. D'Arcy Power, Dr. B. J. O'Neill, Dr. Otto G. Wicherski, Dr. Charles H. Whitman, Dr. Edward T. Dillon, Dr. C. G. Stivers, Dr. Boardman Reed.

Address all communications and manuscripts to

EDITOR SOUTHERN CALIFORNIA PRACTITIONER,

Subscription Price, per annum, \$2.00. 500 Auditorium Building, Los Angeles, Cal.

EDITORIAL

THE O. T. JOHNSON WELFARE STATION.

Through the generosity of the late O. T. Johnson of Los Angeles there has been built a reinforced concrete, two-story and a half building at 926 Yale Street near College Street.

The first floor has a mother's rest room, offices and waiting rooms, treatment rooms for the eye, ear, nose and throat, dental offices and osteopathy treatment rooms.

The second floor has operating rooms, living rooms for the matron and nurses, kitchens, etc.

The basement, well lighted, contains a lecture hall, gymnasium, X-ray laboratory, rooms for Speech and Voice development, and the heating and ventilating and compressed air systems.

There will be a couple of resident nurses and a matron and janitor living in the building so that calls for help may be answered day or night.

The management is under the

Parent-Teacher Federation, Mrs. Elizabeth McManus, Chairman, and Dr. Baneroft, who is at the head of the Health and Development Department of the Public Schools.

The Clinic formerly at Castelar and Alpine Streets, gave medical and dental service to thousands of school children, but it outgrew its quarters and now will have a fine new building.

The attending physicians include Dr. Ross Harris, Ophthalmology; Dr. C. G. Stivers, Ear, Nose and Throat and Speech Defects; Drs. B. King, A. G. Bowman and Minnie Proctor, Dentists; Dr. M. Gilliland, Refractionist; Drs. L. C. Chandler, L. J. Lund and Catherine Lynch, Osteopathists.

Some of its needs are equipment, furniture, and especially an orthodontist to attend to deformed jaws and crooked teeth, which are prevalent in the school children of Los Angeles. Lectures will be given by the Staff, along constructive and educational

lines, such as teaching mothers the care and feeding of children, etc.

Mr. F. O. Johnson, son of the late philanthropist, supervised personally the erection of the building which was designed by Arthur Benton, architect, and also has given much equipment for its furnishing.

What better work could a man do than give such a building for the alleviation of the suffering of children?

NO GOODS ON APPROVAL.

The Supervisors of San Francisco County recently passed an ordinance that only wants the Mayor's signature to become a law, forbidding the taking of wearing apparel, household goods, etc., home on approval. This ordinance backed by the merchants, puts the burden on them by prohibiting them from taking back goods of those varieties likely to suffer by contact with the person or the household or its furnishings.

After all it is an unwelcome thought to think of trying on socks, shirts and underwear that may have been through the same process on the person of one suffering with syphilis, gonorrhoea, skin diseases, tuberculosis, or even lice.

Los Angeles would do well to pass a similar law, as it would do a whole lot to stop the spread of contagious disease.

IN MEMORY OF KENNETH DAY WISE.

Sweetly and softly like the wafting of the perfume of a flower, there passed into immortal life at ten-thirty P.M. in Los Angeles, July 31, 1916, Dr. Kenneth Day Wise. Dr. Wise was born in Henderson, Kentucky, December 29, 1833. He was the seventh child of eleven children and at an early age lost his father. This loss was the beginning of the career of young Wise.

When a boy following the plow on a farm in Indiana he conceived the idea of studying medicine, taking his degree at Jefferson Medical College March 6th, 1864.

He was a lieutenant in the Union Army from 1861-64.

Dr. Wise was a charter member of the Los Angeles County Medical Society; a member of the Pioneer Society of Los Angeles; also of the G. A. R. Stanton Post, who took charge of the burial ceremonies at the cemetery.

Before hospitals existed in Los Angeles, Dr. Wise was performing surgical operations that amazed the public. He was a MacDowell in laparotomies for he had successfully removed an abdominal tumor weighing fifty-nine pounds at a three-room residence in Los Angeles. He was another Emmet in plastic work, using black horse hair, which he prepared himself, for sutures. He performed the first two appendectomies in Los Angeles. For carcinoma he removed two-thirds of the tongue and the patient lived three years afterward. He accidentally, in removing a tumor from the neck, severed the jugular vein thirty years ago and the patient attended Dr. Wise's funeral. He made a resection of the intestines, removed about six ounces of long hair, closed the wound before the Murphy Button was known.

He came to Los Angeles in 1872 and engaged in active practice this year, retiring in 1908. For the betterment of physicians in general and particularly for the welfare of beginning doctors his activities were many. Numerous were the acts of assistance given to the inexperienced doctor, and readily and devotedly did this kindness return to him to be so deeply appreciated in his last illness.

Dr. Wise was the reincarnation of integrity, the soul of squareness and the heart of honesty. No man with more dauntless courage, persistent effort, higher ideals of justice has been placed before the public eye. He was a great lover of the beautiful and possessed a keen sense of humor which carried his patients over many a falling bridge.

Dr. Wise was a great bible student, a man of deep religious principles, from which he never wavered in life, and those who witnessed his passing over the rim of Time felt and believed that he was robbed in the cloak of hope that will rustle throughout an everlasting and immortal destiny.

DR. REBECCA LEE DORSEY.

POLIOMYELITIS.

The following editorial from The Medical Times (New York) September, 1916, proves conclusively that bread cast upon the waters "thou shalt find after many days":

"What Is the Causative Agent of Poliomyelitis?"

"About thirty-five years ago an epidemic of typhoid fever occurred in the city of Los Angeles. As is usual in such emergencies, the conjectures as to the cause of the epidemic were various and many. A solution of the matter was due to the good sense of Dr. Walter Lindley, then city health officer. Dr. Lindley caused a map of the city to be prepared and the locus of each case to be charted thereon. At that time the city was supplied with water from several sources. A careful study of the map revealed the fact that the cases, with one or two exceptions, occurred on the line of a single water supply. A house to house canvass led to nothing tangible, but an inspection of the acequia a few miles outside the city disclosed the source of the trouble. In a part of its course the acequia was open and unprotected. At one place, within a few feet of the water, a Mexican family had occupied an old adobe cabin. They were itinerant, and had stopped there because an adult member of the family was ill; one had died and another was in a dying condition when discovered. The rest of the story needs not be detailed; it has been told many times and in many places.

"The moral—not quite so obvious—

is quite as important. The graphic charting of loci enabled the health physician to search quickly and to investigate intelligently with but little loss of time and practically with neither waste nor misdirection of effort. To the system the credit should be given.

"In the present emergency it is not an unjust criticism to assert that there have been both a waste and a misdirection of effort, for medical and sanitary science are confronted by a problem of many unknown quantities. The geographic locus of the source is unknown; the specific cause is unknown; the manner of infection or contagion is unknown, and the carriers themselves are unknown. A heart-breaking prognosis constitutes our only certain knowledge.

"Solution by elimination may be a slow method; it is often a final means; but almost always it is one of certainties. Perhaps in the present instance the graphic charting of loci may not lead to tangible results, but it surely will not mislead. There are the possibilities of water contamination by means of ice; of fruit and similar food-stuffs purveyed in a thousand shops; of contaminated milk; of infection by insects; and of infection by flying dust. There are sporadic causes in homes where children, who could not have been infected by contact with a human or a domestic animal carrier, have been stricken. Such cases point to one or another of the foregoing possibilities.

"The milk question presents many possibilities; certainly it is a vital one. Fortunately, both the means and the machinery of investigation are already organized. If milk is the medium of infection, it is possible to trace it to the dairies that produce it and to the cows that yield it. If the milk is infected, the cows may also be infected—or they may not be. It is a problem to be solved. And if the cows are infected, what is the source of their infection? Does the infection come from

food?—or from the bite of a skin-piercing insect?

“Up to the present time, bacteriologists admit that the specific germ causing poliomyelitis has not been isolated or identified. Is the failure to isolate it due to the fact that it slips through germ filters? Is it possible that the germ may elude a high-power objective and a stain at the same time? When the commission of European bacteriologists and pathologists investigated the disease popularly known as ‘sleeping sickness’ a germ was sought—but a parasite was finally discovered. Have bacteriologists sought parasites like plasmodia or trypanosomata— or unlike either—as diligently as they have sought germs?

“The investigation of Doctors Rose-nau and Brues have cast suspicion on the biting stable fly as a cause of the disease, and this pestiferous insect certainly has been indicted but not with certainty convicted. If conviction becomes a fact, however, the spread and transmission of infection is possible.

along with one of two lines—or both of them. Milk may be a carrier; the dung element of flying street dust also may be a carrier. Who can say positively that either one is or is not? The driver who delivers milk and the grocer, who slops it out of a deep can with a long handled dipper may be a carrier. Who can say that either one is or is not?

“No one can bring a charge of incompetency against, the leading American bacteriologists, pathologists and sanitarians; they rank with the best in the world. But can it be said that our systems and methods of research are as well organized and co-ordinated as well as that, say, of Germany. When the British government invited co-operation in the investigation of sleeping sickness, a master hand effected an organized system of work. The result was a foregone conclusion. It was not the work of any one man’s work, and it is doubtful if any one man working independently could have achieved the discovery. To organized and co-ordinated system the credit should be given.”

EDITORIAL NOTES

Dr. Sandford Whiting has located in the Citizens National Bank building.

Dr. Charles G. Wharton has located his offices in the Consolidated Realty building.

Wanted—Test case, Perimeter Ophthalmoscope and eye, ear, nose and throat instruments. Address P. O. Box 1958, Los Angeles.

Wanted—By trained office assistant, position in physician’s office, stenographer and bookkeeper; references. Call West 1241. Address 1506 Arapahoe Street.

Dr. L. Graham of Fresno is pursuing post-graduate work at the medical department of the University of California, Los Angeles. He is specializing on eye, ear, nose and throat.

Dr. H. W. Edgerton of Pomona is taking special studies in eye, ear, nose and throat branches at the Post-Graduate Medical School of the University of California, Los Angeles.

Dr. John Adams Colliver describes a New Preparalytic Symptom of poliomyelitis which is a peculiar twitching, tremulous or convulsive muscles lasting from a few seconds to less than a minute, resembling light cases of strychnia poisoning.

Dr. Daniel H. Williams, a negro, was the first surgeon to successfully perform an operation on the human heart. In the organization at Chicago in 1913 of the American College of Surgeons he was chosen as a charter member. Science draws no color line.

On account of going East for post-graduate work and to visit relatives, I desire to dispose of my practice. A good opportunity for a live, energetic man. No real estate to sell. Only furniture and fixtures of 10 rooms, part used for hospital. For particulars address Dr. S. Pinniger, Tracy, Cal., San Joaquin Co.

The Albuquerque Sectional Conference on Tuberculosis of the National Association for the Study and Prevention of Tuberculosis will meet at Albuquerque, New Mexico, October 12 and 13. Dr. W. Jarvis Barlow of Los Angeles is a vice-president and Dr. L. M. Powers, our efficient Health Officer, will address the meeting. Dr. C. C. Browning is to discuss the Indigent Migratory Consumptive.

The Alumni Association of the University of Pennsylvania of the Pacific Southwest started and organized by the writer of these lines many years ago is paying the tuition fees of a young Los Angeles student of architecture at the Architectural School of the University of Pennsylvania. The Alumni are mostly doctors, with some dentists, lawyers and business men.

At the October meeting of the Eye and Ear Section of the Los Angeles County Medical Association, Dr. J. J. Kyle read a paper on "Epidemic Sinus Infection." Discussion was extended and instructive. Clinical cases were shown by Drs. Stivers, Harris, George W. McCoy, Detling and Rogers of Long Beach. There were seven visiting physicians from various parts of the world. C. G. Stivers, Secretary.

The Southern California Society for the Advancement of Medical Research is an organization that is worth while. At its meeting held September 30th there was the following programme:

1. A Preliminary Report on a Case of Polycythaemia with Splenomegaly and Cyanosis. By John F. Barrows.

2. On the Proteolytic Power of Serum in Pregnancy. By Lyman Stookey.
3. A note on Sensory Nerve-endings in the Extrinsic Eye-muscles. "Atypical Motor-endings of Retzius." By H. O. White.

The Management of the Speech Defect Problem in the Public Schools. By Walter B. Swift, M.D., Harvard Medical School, Boston, Mass. Educational Administration and Supervision, March, 1916. Summary: In brief, the management of the speech defect problem in the public schools demands a medical speech inspector to see all pupils and assign them to either a phonetic, stuttering, or a special class, and to have at the head of each of these divisions a teacher specially trained in one of these lines alone.

Examination of Voice Defects Following Adenoid and Tonsil Operations. Studies in Speech Disorder No. 4. By Walter B. Swift, M.D., Harvard Medical School, Boston, Mass. The Boston Medical and Surgical Journal, November 18, 1915. Summary: Operations for adenoids and tonsils often fail to relieve habits of faulty articulation and consequent school retardation. Vocal drill by one trained scientifically in speech disorder is the surest method to secure speedy permanent relief, in that perfect articulation that makes possible an easy enjoyable conversation.

Dr. Henry R. Harrower and a number of local members of the recently formed Association for the Study of the Internal Secretions gave an informal dinner, September 20th, at the Hotel Clark, to Dr. Harvey G. Beek, professor of medicine in the University of Maryland. Twenty-five plates were laid. The discussion naturally turned to matters pertaining to the ductless glands. The next evening, Doctor Beek addressed the County Medical Society on "Fat Dystrophies of Internal Secretary Origin." Thanks to Doctor Harrower's enthusiastic interest, the profession in

Los Angeles is continually being reminded of the importance of the endocrine glands.

Big Dam Full of Fish.—Roosevelt dam, head of the Salt River Valley Reclamation project, abounds with game fish. Bass, planted there by the United States Government since the reservoir began to fill with water, have multiplied many thousand fold, and there are crappie, salmon, perch and trout beside. In the shallows, soft-shell turtle and carp abound. Land-locked salmon in this lake, very like the Scotch variety, often are caught three feet long. There are hotel accommodations, boats, and fishing tackle at the lake. The lake has become a popular week-end resort, and tourists pass that way in great numbers. The dam is eighty miles east of Phoenix, and the ride, across the desert and over the mountains, is full of interest.

Mrs. Mary B. Ritter, of the California Federation of Women's Clubs, says: "For the educative anti-tuberculosis crusade there is no end. Again sane, sound, non-spectacular, non-melodramatic education on the question of sex hygiene and of vivisection is needed sorely. Both should have careful handling, by physicians and parents preferably. Children must be taught sex hygiene. The how and when are the all-important factors. As to vivisection, sanity is again all-important. In passing may I ask how the knowledge above referred to about the prevention of typhoid, plague, etc., could have been obtained without experimentation upon animals? Humane treatment in the experimenting is the great desideratum. The 'twilight sleep,' and State insurance for health, are other topics upon which education will be needed during the coming club year."

BOOK REVIEWS

A PRACTICAL TREATISE on Disorders of the Sexual Function in the Male and Female. By Max Hühner, M.D., Chief of Clinic, Genito-urinary Department, Mt. Sinai Hospital Dispensary, New York City, etc. Published by F. A. Davis Company, Philadelphia, 1916.

The author states in the preface that although the major portion of the sexual neurasthenics come, not to the genitourinary clinic, but to the neurological clinics, it is in the domain of the former that the diagnosis and treatment can best be carried on, for the reasons that few neurologists are familiar with the pathological appearance of the deep urethra, the feel of an enlarged prostate or the sequellae of chronic gonorrhoea, all of which knowledge is of the utmost importance in the treatment of sexual neurasthenia.

The subject of masturbation is accorded a full consideration and its treatment directed along well recognized therapeutic lines. The reason

why bromides do not cure it is that they begin at the wrong end. Bromides dull the brain-cells but do not remove the hypersthesia of the prostatic urethra, which condition needs local treatment given by the genitourinary surgeon.

It is an exaggerated sense of the importance of masturbation that leads Steinbacher (quoted by Hühner) to ascribe stuttering to it as well as a long list of diseases beginning with asthma and ending with insanity. There is on the other hand no warrant for the indifference of many general practitioners who pass it by as a well nigh inevitable phase in the course of adolescence. Hühner recognizes the importance of the role of the woman in both normal and abnormal coitus. The callous indifference of the average man to the lack of preparedness of his wife when he desires coitus comes in

for a well merited rebuke. Withdrawal is blamed for much of the impotence of early middle life as it reacts on both husband and wife to their detriment.

INTERNATIONAL CLINICS. A Quarterly of illustrated clinical lectures and especially prepared original articles on treatment, Medicine, Surgery, Neurology, Paediatrics, Obstetrics, Gynaecology, Orthopaedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and other topics of interest to students and practitioners by leading members of the medical profession throughout the world. Edited by H. R. M. Landis, M.D., Philadelphia. Volume III, Twenty-sixth series, 1916. J. B. Lippincott Company.

Very practical articles found in this volume embrace "Gonorrhoea in the male," "The treatment of Obesity," "The medical uses of high-frequency currents," "X-ray in Pulmonary tuberculosis," "Tuberculosis from Röntgenological standpoint," "Diagnosis of thoracic adenites," "Analysis of 50 cases of disthyroidism," "Diphtheria toxin skin reaction," "Herpes Zoster," etc.

A TEXT-BOOK OF HUMAN PHYSIOLOGY, including a section on Physiologic Apparatus. By Albert P. Brubaker, A.M., M.D., Professor of Physiology and Medical Jurisprudence in the Jefferson Medical College, etc. Fifth edition, revised and enlarged with one colored plate and 359 illustrations. P. Blakiston's Son & Co., Philadelphia. Price \$3.00 net.

This is a well written and admirably arranged text-book on Physiology designed to meet the needs of students and practitioners of medicine.

THE CLINICS OF JOHN B. MURPHY, M.D., at Mercy Hospital, Chicago. Volume V, Number 4 (August, 1916). Octavo of 222 pages, 59 illustrations. Philadelphia and London: W. B. Saunders Company, 1916. Published Bimonthly. Price per year: Paper, \$8.00; Cloth, \$12.00.

Now that the great man has passed on to other spheres of development and we who have known him will not be able as we once did to listen to the magic of his teaching and to the magnetism of his enthusiasm, trying to achieve a measure however small of his

great charity, it is some comfort to have these clinics left to us.

The present volume maintains the high standard set by the previous ones—and is a fitting addition to any practitioner's library.

THE MEDICAL CLINICS OF CHICAGO. Volume II, Number II (September, 1916), Octavo 196 pages, 22 illustrations. Philadelphia and London: W. B. Saunders Company, 1916. Price per year: Paper, \$8.00; cloth, \$12.00.

Published bimonthly by W. B. Saunders Company, Philadelphia and London.

The next best thing to making a personal visit to Chicago for clinical work is to have the subject presented in book form as in the volume under review. These are excellent articles: "Acute Miliary Tuberculosis," "Syphilis of the Liver," "Feeding the Normal Baby with Artificial Foods," "An Unusual Case of Multiple Sclerosis," "Progressive Muscular Atrophy," "Carcinoma of the Head of the Pancreas," "Chronic Bronchitis, Emphysema, Marked Cyanosis," "Etiology and Treatment of Aene," "Diabetes in the Young," "A Case of Renal Glycosuria," "Chronic Diarrhoeas," "Syphilis of the Stomach," "Pleurisy and Gastric Spasm," "A Case of Myelogenous Leukaemia," "Differential Diagnosis of a Case with an Enormous Number of Red Cells," etc.

Practical Medicine Series—1916—one of a series of 10 vols., published yearly, at about monthly intervals, covering the entire field of medicine and surgery. Although published primarily for the general practitioner its arrangement in several volumes enables the specialist to select what is best adapted to his needs.

Vol. iv. Gynecology—Contains the "Dernier Cri" on this subject compiled by Dudley and Stowe.

Vol. v. Pediatrics and Orthopedic Surgery. The latest facts collected by

Abt and Ridlon. The price of separate volumes is \$1.35 and of the ten volumes \$10.00. The Year Book Publishers, Chicago, 40 Dearborn St.

AN IMPOSTOR.

A man who styles himself B. F. Little has recently been collecting money from physicians in Oregon and Washington under the pretense of being a representative of D. Appleton & Company, the medical book publishers of New York. The man's plan is to say that he is collecting for the Western Students Benefit Association of Denver, Colo. Doctors in Payallup, Wash., and Coquille, Ore., are reported to have been his victims.

D. Appleton & Company are endeavoring to have the fact made known to doctors in the Far West that this man is an impostor and has no connection whatever with their firm, and that any payments which are made to him are of course at the risk of the doctor.

HALF A CENTURY'S PROGRESS.

October, 1916, points an epoch in the history of Parke, Davis & Co. The house was founded in 1866—just fifty years ago this month—largely upon the optimism of three or four determined men, backed by a capital that would seem insignificant today. There was nothing in its unpretentious origin to foretell the success of after-years. And by success we mean not merely material prosperity, but also that broader and more enduring success that is based upon good-will and confidence.

Manufacturing pharmacy was then a crude, imperfect art. Bacteriology, pharmacology and biological pharmacy were as yet unborn. There were no curative sera or vaccines in those days. Prophylaxis was in its infancy. Standardization was unknown.

Fifty years have wrought marvelous changes in means and methods for the

treatment of human ills. The materia medica has been amplified beyond the dreams of the earlier investigators. Knowledge of pathology has immensely broadened. The empiricism of the past has given way to rational therapeutics, and medicine is taking its rightful place among the sciences.

In all these forward movements Parke, Davis & Co. have had some part—notably as discoverers of new vegetable drugs, as inventors of new chemical compounds, as pathfinders and producers in the field of biological manufacture, as investigators in original research, as pioneers in both chemical and physiological standardization.

The past half-century, as we have intimated, has been remarkable in its contributions to the newer materia medica. What will the next fifty years bring forward? Time alone can write the answer. Ours is a progressive age. The science of medicine has not reached its highest development. The physician's armamentarium will be further enlarged and fortified. New remedial agents will come into being. Many existing products will be improved. And with the fulfillment of these conditions, Parke, Davis & Co. (if we may judge the future by the past) are certain to be identified.

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SOUTHERN CALIFORNIA PRACTITIONER

Vol. XXXI.

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No. 11

Editor,

DR. GEO. E. MALSBARY.

Associate Editors,

Dr. Walter Lindley, Dr. W. W. Watkins, Dr. Elbert Wing, Dr. Ross Moore, Dr. George L. Cole, Dr. Cecil E. Reynolds, Dr. William A. Edwards, Dr. Andrew W. Morton, Dr. H. D'Arcy Power, Dr. B. J. O'Neill, Dr. Otto G. Wicherski, Dr. Charles H. Whitman, Dr. Edward T. Dillon, Dr. C. G. Stivers, Dr. Boardman Reed.

REED'S BACILLUS OF EPILEPSY.

BY A. J. HINKELMANN, GALESBURG, ILL., DIRECTOR GALESBURG LABORATORY.

(With One Illustration.)

Through the work of Reed,* the question of a specific organism as the exciting cause of the seizures of epilepsy has been set forth. Having previously worked from a different basis with an organism I believe is the same as the one isolated by Reed, and having since the appearance of his articles, succeeded in finding the organism in the blood of an isolated case of epilepsy, I am in a position to add a few facts to what Reed has already said. I am sure this will be of further aid to the profession in the direction of reaching final conclusions as to the significance of the organism.

Method of Invasion of the Human System.

Under this head, Reed has made very clear the point that the organism is evidently taken into the intestinal tract by way of the mouth, and enters the blood through a cecal or an appendiceal focus, and leaves the question open as to the danger of communication. What

would be the consequence in case the organism was ingested by a normal individual, and to what extent may those with predisposing lesions expect to escape infection?

From a basis of experiments I conducted during the summer of 1915, and before I had any knowledge of the pathology of the organism, it may be stated that it is a very frequent inhabitant of the intestinal tract of probably the majority of people. My conclusions at the time of my experiments were that it is one of the regular members of the so-called intestinal bacteria.

My interest in the organism was its high resistance to germicidal agents, and through this fact it becomes an easy matter to demonstrate its presence in the intestinal flora and also that it is commonly present. It will live in phenol solutions of from 5 to 10 per cent for many hours and a much higher strength is necessary to kill it instantly. Among the very large number of different species of bacteria that are usually

*Reed, Charles A. L.—Journal of the American Medical Association, January 29, and May 20, 1916.

found in the intestines, it is commonly the only one that will survive a thorough treatment of the stool with a 5 or 10 per cent phenol solution.

My method of isolation was as follows: From 25 to 30 grams of solid feces were made into an emulsion with 50 cc. of a 5 per cent solution of phenol and allowed to stand for 30 minutes or an hour; cultures were made on agar slants and incubated. I have never made such cultures from the stools of epileptics with the view of noting how numerously the organism is present, but in normal individuals, a loopful of the above emulsion spread over an agar slant will yield from 1 to 6 colonies after twenty-four hours of incubation.

The organism is highly haemolytic, and to this last fact may be due a part of the pathological conditions present in epileptics. Cultures made on blood agar plates will show a haemolytic spot at the point of a growing colony long before the colony itself becomes visible. In the case that came under my observation, I found it abundantly present in the capillaries, and both the spores and the organism could easily be demonstrated in smears from the blood directly.

Conclusion.

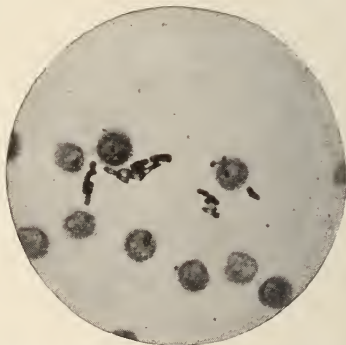
In view of the fact that the organism does enter the circulation and there multiplies into great numbers and is so generally found in the blood of epileptics, the conclusions of Reed as to its specific nature become at least very plausible. It would be hard to conceive that an organism with such a high haemolytic property could enter the circulation and multiply to such numbers as smear preparations from the blood indicate without producing diseased conditions within and resulting in corresponding clinical manifestations without.

At any rate, what has already been established in regard to the organism makes the question one most worthy of serious consideration and extensive in-

vestigation. The universal presence of the organism in the intestinal flora is no argument against its probable pathology, but simply adds to the importance of the gateway through which it enters the blood stream, in consideration of the question of treatment.

If further investigation should finally establish that the bacillus epilepticus is the exciting cause of the seizures of this disease, little probably can be hoped for in the way of prophylaxis or cure through efforts to prevent the organism from entering the intestinal tract or to eradicate it when present. The best attention probably will have to be directed toward those lesions which open the way for it from the intestines into the circulation.—New York Medical Journal.

LEGEND.



Bacillus epilepticus directly in blood smear from an epileptic patient five hours after seizure.

During this unusually foggy weather on the coast, it is a delight for a person with influenza or bronchitis to be in Brawley, El Centro, Calipatria or Calexico in the Imperial Valley and see the sunrise and in the evening the wonderful sunset of the desert. We have been enjoying this felicity and lost, in a few days, a cold that had been annoying us for weeks. The Oregon, at El Centro, is a hotel with comfortable rooms, good service and reasonable prices.

PROBLEMS IN RELATION TO THE LOS ANGELES COUNTY HEALTH OFFICE.*

BY J. L. POMEROY, M.D., FULL-TIME HEALTH OFFICER LOS ANGELES COUNTY.

If the public health work of a County Health Office is to successfully meet the demands of the keen driving force of efficiency experts, we shall need new and broader legislation; more generous budget allowances, and a kind of co-operation that is not interference. If the day of shotgun methods of sanitation is really passed, if the new spirit of national preparedness is a vital reaction, and if the awakening of all the powerful social forces to the great problem of national conservation of life represents an actual desire of the people of the nation, and not a kind of national hysteria, then the Health Officer should be able to plan on the basis of efficiency and economy, and go forward with the full support of all the best of these agencies. We must in truth react to these national movements in no uncertain way. Either the Health Officer must organize his forces along proper administrative lines with an accurate budget system; must outline his work with a rigid system of relative values, and properly segregated functions, or those great social forces which have already so successfully handled certain phases of the work will permanently invade the field of public health.

There are at the present time many influences at work in public health conceived for the performance of certain functions which on close examination invade the domain of public health. Besides official agencies of various state and municipal bureaus, there are many powerful voluntary agencies which must be considered. It would appear that whatever belongs to public health should come under the administration of those forces legally in-

tended by the state to administer this function. I view with regret the tendency to parcel out the business of the various functions of public health to a multiplicity of agencies demanding the co-operation of the local health officer to his great confusion, and often actual bewilderment. Such conditions lead to actual overlapping, much waste of public money, and in times of stress, diffusion of energy.

I would like therefore to outline briefly some actual problems in relation to the County Health Office of Los Angeles:

The County Health Office is apparently designed to take care of the problems of rural hygiene. The term "rural" in Los Angeles County is somewhat lacking in precision. Our present territory covers in the aggregate nearly 4000 square miles. In this section we have a combination of desert, mountain, valley, and coastal region. We have the great metropolis of Los Angeles County—the third largest in area in the United States, and 36 smaller municipalities which are incorporated. In addition to these incorporated cities are about 35 groups of people living under conditions approximating the small city. In one section we have a group of 12,000 people, which is in no sense rural. The percentage of people living in places of 22,500 or more in Los Angeles County in 1910 was 81.7%, an increase of 11.1% over 1900. The marvelous development of our good road system, the rapid transit facilities, and conditions of labor have made of our county almost one large family. The facilities for the rapid spread of disease, the tendencies for influences affecting one locality to reach far dis-

*Read before the Health Officers' Section of the California League of Municipalities, Visalia, October 9, 1916.

tant places are a factor of modern development quite recent indeed. No longer does a city or town live in isolation characteristic of the time when most of our public health laws were written. While it is true that a relatively large percentage of people still live under rural conditions, the factors of rapid transit make these conditions a vital part of the entire county, and the public health work of the county must inevitably be reorganized to meet these changed influences.

The life of the health office depends upon the budget. The preparation of scientific budget means an accurate knowledge of vital statistics, and if true economy is to be affected, an efficient administrative system. Financing is a business in itself, and the demands of the present day compel us to weigh each function according to some standard of relative values which will accomplish definite results in the prevention of disease.

An enormous amount of publicity has been given the cause of rural sanitation in the United States. Practically we have had to deal in our budget making with the simple expenditures of the past few years as a basis.

I will submit a few figures:

In 1912-1913, there were 439 cases of communicable disease, with 333 deaths. The total deaths from all causes was 1208. Expense of the health officer, \$7330.19.

In 1913-1914 there were 275 cases of communicable disease with 335 deaths. Total deaths all causes, 1140. Total expense of the health office, \$5452.09.

In 1914-1915 there were 634 cases of communicable disease reported, with 358 fatalities. Total expense of the health office, \$7022.00.

In May, 1915, when I took charge of the office, the staff consisted simply of the health officer and fumigator. During the past year and a half we have added one stenographic clerk, a deputy health officer, and two rural nurses,

with a total expense last year of \$9659.42. Our budget for the coming year gives us \$15,297.07.

During the past year we have traveled over 26,000 miles throughout the county. The experience of the past eighteen months brings me to the following conclusions:

First: That scientific budget-making of a County Health Office, such as Los Angeles County, should be based upon a district organization in order to effect a real economy in transportation and rapidity of action with the health of the local community spirit which would naturally follow the full time district health officer.

The fate of the public health work of the unincorporated section and the small city is absolutely identical. Their administrative unity is rapidly becoming a necessity. The spread of infectious disease does not recognize any political subdivisions or city boundaries whatever. Under the present system we can increase our budget from year to year indefinitely, but without any corresponding increase in efficiency, nor can we force the smaller city to automatically improve conditions or increase its budget.

A survey made of 29 small cities representing 73,000 people, appropriated last year for the prevention of disease less than \$6000. Of 33 towns there were but five with properly organized health boards or health officers. In these cities we have been compelled to make investigations and actually perform their work. In five cities the health officer received \$5.00 a month; in three cities, \$10.00 a month; in three cities, \$20.00 to \$30.00; in four cities, \$40.00; in two cities, \$50.00 a month. It can easily be seen that no matter to what extent we build up our County Health Office, to the ultimate fate of the public health work outside of the larger cities depends upon the efficiency of the small town. The fact that a particular locality is backed in public

health, hampers our efficiency very greatly, but should not relieve it of the responsibility therefor.

2. Vital Statistics.

As the basis of all proper administration is an accurate knowledge of vital statistics, the present conditions are very confusing. Many deaths from our territory take place in the hospitals in the towns. Our own Bureau of Vital Statistics is under the County Recorder, which does not offer us adequate facilities, and furthermore, the returns from the smaller cities are sent direct to Sacramento.

We greatly need a clearing house on vital statistics that would segregate these deaths to the territory where they properly should be charged.

In conclusion I beg to state that it is an extremely difficult matter to cover the fundamentals of efficient health work in a few moments or to adequately describe the confusion of interests modern progress has created by complex organizations working in the same field.

The solution of the difficulties in Los Angeles County is the establishment by law of a means of the organization of small cities and rural territory into districts,* in which the administration should be centralized in a full time health officer in such a manner that the county would be divided exclusive of the City of Los Angeles, into about seven districts under such a system that the County Health Office could act as a clearing house for all of the districts in the county, and its various functions could be separated in such a manner that the present over-lapping would cease to exist. The City of Los Angeles will, like New York, adopt the borough system of government, and the health department of the city will be compelled to recognize the district plan as the only rational way of efficient government in public health.

*The health offices section at Visalia adopted for presentation to the State Legislature a bill which will enable cities, cities and counties, or parts of either to form health districts.

THE DIAGNOSIS OF THE INTERNAL SECRETORY DISEASES.

BY HENRY R. HARROWER, M.D., F.R.S.M. (LOND.), LOS ANGELES, CAL.

VII.

The Diseases of the Thymus.

DISORDERS of the thymus gland are not common, though they are undoubtedly more frequent than is supposed. The growing appreciation of the important work and relations of the ductless glands, including of course the thymus, has sharpened our sensibilities and powers of observation, and in consequence thymus disease is being diagnosed more often, thus opening up still another field for therapeutic effort.

There always has seemed to be an element of mystery about this gland, due possibly to the strangeness and suddenness of deaths of thymic origin. However this is being replaced and a

number of points have been established which enable us to consider thymus disease with prospective advantage.

As with the other ductless glands, we may find a cellular enlargement of the thymus with local symptoms due to pressure; or, on the other hand, there may be change in the functional activities of the gland with varying effects upon the body as a whole. It is not yet generally conceded that the thymus is really a gland of internal secretion, although there seems to be sufficient evidence that it influences metabolism and also the work of the other ductless glands in a manner very similar to the

other organs which we know are endocrine glands.

It has been suggested that the principal function of the thymus is to produce lymphocytes, and that any effects that it may exert upon metabolism, positive or negative, are due to these cells or their contents. Sajous remarks that the bulk of the available evidence points to this mode of transmission, viz., through the agency of lymphocytes which develop in the thymus. Of course it is quite possible that these blood cells carry within themselves certain chemical substances which are very closely allied to hormones, if not actually such.

Physiological Considerations.

Most authorities consider the thymus as a temporary organ which reaches its height of development about the age of two, and retrogrades slowly until puberty, at which time it is supposed to disappear, though this opinion is not unanimous. Proof that the thymus is not a lymphoid organ alone seems to be found in the clinical and experimental work which has shown an intimate relation between the action of the thymus and the metabolism of the mineral salts, especially of calcium and phosphorus. For when there is thymus dysfunction the chief organs to suffer from the resultant chemical changes are the bones, muscles and, perhaps, the nerves, in the order named.

There is an abundance of evidence connecting the activities of the thymus with those of the gonads. It seems that the thymus antagonizes the action of the sex glands, and that increased thymus function, especially during the period of development, causes deficient reproductive development; while, on the other hand, deficient thymus activity may cause an increase in the growth and function of the gonads. At least we know that if the thymus does not retrograde in the usual manner at puberty there likely may be evidences of defective sexual development.

Another important clinical fact which indicates another physiologic intimacy of the thymus is found in its relation to idiocy in children. It has been remarked that a large percentage of idiotic children have no thymus at all. Morel reports that of over four hundred idiotic children with normal thyroids coming to autopsy, over 75% possessed no thymus. In passing it is interesting to note that Klose has experimentally shown that thymectomy in dogs is followed by a gradual change in the mental powers until a condition which he terms *idiotia thymopriva* is present. While this does not necessarily prove that *athymia* is the cause of idiocy, it is at least a very suggestive finding and one which has been well established by many investigators.

Thymus Insufficiency.

Experimental proof is at hand to show that the removal of the thymus from animals causes a decided reduction of growth—dwarfism. It is not improper to presume that this holds good with children. At least there is a probable thymic element in dwarfism, and support of this is found in several communications which report benefit following thymus feeding in certain cases where weight is low and the height reduced.

Certain nutritional disorders in children, notably *marasmus*, are quite commonly associated with thymic atrophy, and some interesting clinical proof of this is available. Deficient children, especially when there are disturbances in bone growth and development, should always be considered as thymus cases until definitely proved not to be suffering from *hypothyism*.

Naturally *hypothyism* is not to be expected in adults for the gland normally becomes inactive at or near puberty. However individuals with thymus dyseracias in childhood may retain certain chemico-nutritional disorders as a result of the previous disordered function of this gland.

The blood changes are not characteristic; but one frequently finds hypothyroidism accompanied by anemia and especially lymphocythemia. Reduced coagulability is also common and frequent bleeding at the nose may be the first indication of thymus disorder. Reference has already been made to the relation of hypothyroidism (or athymia) to mental insufficiency. Still another incidental defect has been connected with dysthymism. Browning states that there is a relationship between the thymus gland and stammering. While all cases with an enlarged thymus do not stutter, all stutters will be found to have an enlarged gland. This is denied by such authorities as MacCuen Smith, but is worth remembering. After all success in the detection and treatment of ductless glandular disorders is attained by noting insignificant things and the writer has "got on to" at least one case of endocrine disorder by noting that the patient stuttered.

One frequently notes a peculiar condition of hairlessness (especially of the head and face) and a yellowish, parchment-like skin in pluriglandular dyscrasias in which the thymus element is or has been prominent. Parenthetically it may be well to remark that Sajous suggests that progeria or premature senility (usually in children) is really due to thymus disease.

Some of the findings in experimental and clinical work are sometimes contradictory, and the reason for this is due to the fact that the endocrine organs are so intimately connected with one another. At one time a certain hormone seems to be in the ascendency whereas at another it is deficient. As an instance of this a case of presumed hypothyroidism with retarded growth and sexual development was treated with thymus substance for some months with a remarkable increase in height and general progress, though it must be recalled that theoretically the re-

moval of the antagonism of the thymus (as in hypothyroidism) should favor functional gonad activity and the developmental and other results thereof.

Hyperthymism.

Hyperthymism is not a common or easily diagnosed condition. It is rarely found unaccompanied by other ductless glandular disorders, indeed it is a disorder which one should be ready to look for mainly in connection with certain forms of thyroid excess. A number of experiences in the literature on this subject indicate that one should carefully look for an enlarged thymus and evidences of its excessive activity in every case of Grave's disease, and particularly before surgical intervention is undertaken.

After a careful search both of the literature and numerous unpublished hospital records, Matti collated 133 cases of sudden death in hyperthyroidism in which a post-mortem examination had been held and in 98 cases, or 74%, a hyperplastic thymus was found. Such records emphasize the advice just given regarding the relation of thymus disorders with Grave's disease.

A number of deaths have followed thyroid operations, due to thymus complications. Not a few times a share, at least, of the heart and nervous symptoms attributed to hyperthyroidism has been due to a concomitant hyperthymism. In this connection it must be emphasized that while an enlarged thymus is usual in such cases, there is no doubt that the degree of thymotoxemia may have little to do with the size of the gland.

Experimentally and clinically excessive thymus function is accompanied by severe general nervousness, tremor and a rapid irregular pulse. Thymotoxemia of this character may be amenable to roentgenization of the thymus area.

There is a somewhat rare thymus type of adiposity which is usually accompanied by lymphatic tendencies,

and in which one often may find a well defined thymus area on X-ray examination. In such cases myasthenia is persistent and may disappear after suitable treatment—roentgen or surgical.

In cases with thymus disorder one usually will find a considerable increase in the number of lymphocytes in the differential blood count, and this procedure is recommended not merely when thymus disease is suspected, but in the routine clinical diagnosis of Grave's disease.

According to Paltauf the characteristic features of hyperthymism are as follows:

1. Hyperplasia of the various groups of lymph glands, tonsils, spleen, and, of course, the thymus itself (see status thymo-lymphaticus);

2. Lymphocytosis, the count being increased to 50% or more (i. e., increased 100% or more);

3. Cardio-aortic aplasia;

4. Maldevelopment of the genital glands and their adnexa; and

5. A pale, badly nourished skin with scanty hair and an exaggerated panniculus adiposus.

It is fair to add that one rarely finds all these in a single case.

Attention has already been called to the value of the roentgen ray in the diagnosis of thymus disorder. An enlarged thymus occasionally may be percussed as a triangular area of dullness under the manubrium of the sternum, in some cases extending outward on either side a short distance. This area of dullness may move slightly upward on extending the neck by drawing the head well back. The base of this triangle is between the sternal ends of the clavicles, and the apex between the junctions of the sternum with the second and third ribs. Halstead has noticed that downward pressure on the sternum may produce a sense of suffocation in cases of this character, which differs considerably from the normal.

It should be recalled that there is such a condition as a substernal goiter or an intrathracic thyroid; but this may be differentiated by the somewhat higher position of the enlargement and the fact that it moves with the trachea in the act of swallowing.

Hoxie has described a symptom complex in which an enlarged thymus is accompanied by shortness of breath and discomfort in the thorax, and extreme muscular weakness. In several cases reported the asthenia was quite the most prominent subjective finding. This is of special interest as there seems to be clinical evidence that myasthenia gravis is in some way connected with the thymus. Tom Williams has reported a case of a man with this disease who was apparently cured by the administration of thymus substance.

Thymus Hyperplasia in Children.

We have already referred to the symptoms of thymus enlargement and hyperactivity; but thymus hyperplasia in children deserves mention by itself. It seems to be a somewhat different clinical entity not uncommonly found in infants and children and, unfortunately, too often only at the autopsy table. Many times this hyperplasia causes no well defined symptoms and is altogether latent until sudden death, the so-called "mors thymica" is the first indication that something was wrong.

In infants where an enlarged thymus is present, the initiation of breathing may be a prolonged and difficult matter. The cyanosis present at birth may persist and the breathing may be difficult and stridorous. In such cases the outcome is often fatal after a few hours or days.

Dyspnea in children is probably the most marked symptom of thymus hyperplasia, and its presence should always cause a careful search for other associated findings. It may vary in degree, depending upon the pressure, from an insignificant stridor worse on stretching

the neck or drawing back the head, to a serious and alarming air hunger.

In such cases the general health is poor. The skin has a pasty, badly nourished appearance, not unlike that of cretinism. There may be vague respiratory symptoms due to tracheostenosis, which later may develop into a peculiar harsh and intermittent cough which is sometimes erroneously called a "tooth" cough, a "stomach" cough or, for the lack of a better name (much the same as "neurasthenia") a "nervous cough." This cough occasionally may be short and dry during the day and considerably worse at night. It is possible that the cough may not be due to pressure on the air passages, but to irritation of either the recurrent laryngeal or vagus nerves, although tracheal stenosis is the most usual cause.

Status Thymo-lymphaticus.

This disorder differs somewhat from thymus hyperplasia since it is evidently an acquired condition and is more frequently observed in older children and young adults. It is a more complex condition, the hypertrophic changes in the thymus being accompanied by a general enlargement of the bronchial, mesenteric and other lymphatic glands. According to Hart, the existence of a true status lymphaticus has not yet been proved with absolute certainty. To Hart it appears that the swelling of the lymphatic apparatus represents a tissue reaction dependent on the thymus and which may show itself also in the lymphoid components of the thymus itself.

Adenoids and enlarged tonsils are usual, hence cases with a well marked adenoid facies and other evidences of lymphatic enlargement should be studied as likely cases of status lymphaticus and the thymus should be sought for and, if possible, measured. According to Bierring and others, unexplainable deafness has been found in a number of cases.

In the past status thymo-lymphaticus commonly has been diagnosed after sudden and unexplained death. We are now better posted on the symptomatology of thymus dyscrasias, and with increasing frequency this condition is detected before extreme results show themselves and in time to perform thymectomy or, perhaps, to treat the thymus with the roentgen ray. (This operation is not to be advised save in emergencies. Such individuals do not bear an anesthetic well—thymus death has not infrequently occurred on the operating table—and where the operation seems urgently indicated, if possible a course of radiotherapy should be tried first.)

Individuals with status thymo-lymphaticus usually are of the flabby, semi-obese type, with a peculiar pasty appearance of the skin of the exposed parts. Pigmentation is occasionally seen, especially in cases of Grave's disease with thymus involvement. Incidentally the records of the pathological department of the Johns Hopkins Hospital indicate that adrenal atrophy (and presumably adrenal insufficiency) is common in cases dying from status thymo-lymphaticus. Asthenia is a usual symptom and sometimes overshadows the other subjective symptoms, and, presumably, it is of adrenal origin. Such cases often suffer from severe metabolic disorders with an intoxication which is quite probably of endocrine origin.

Quite often the development of the bones is disturbed, the growth of the extremities being stunted and a condition of softening quite similar to osteomalacia has been attributed to thymus disorders. At least derangements of the calcium metabolism are quite usual in thymus disease, and there is plenty of evidence that the thymus is concerned in the regulation of the mineral balance of the body.

The circulatory system is ineffective due to hypoplastic changes in the heart

and great vessels. As a result of these organic changes resistance to disease is low, "the constitution is poor" and trivial things may produce sudden death. In young individuals the abdomen frequently assumes that type known as "pot belly" and there is an important clinical connection between thymus disorder and rickets.

Thymic Asthma.

The dyspnea of thymic origin has somewhat erroneously acquired the name "thymic asthma." This is really a form of inspiratory dyspnea due most usually to tracheostenosis caused by pressure by an enlarged thymus. It is only one of a series of symptoms of thymus hyperplasia and is not a distinct clinical entity, nor is it amenable to treatment different from that which is directed at the removal of the thymus or, at least, the pressure that it exerts upon the structures adjacent to it.

715 Baker-Detwiler Bldg.

Next Month: "Internal Secretary Irregularities of the Gonads."

IN RE THE BACILLUS EPILEPTICUS.

Dear Dr. Malsbary:

I am enclosing you the proof slip of an article by Hinkelmann, with the request that you kindly publish the same in the next issue of your journal, with due credit to the New York Medical Journal.

The facts underlying this rather unusual request are as follows:

Several months ago, I published an article on the B. epilepticus, utilizing the Journal of the American Medical Association as the medium through which to reach the largest number of the profession. The organism is naturally under investigation by the profession at large, and the profession at

large is entitled to all the evidence in the case. Hinkelmann's article was and is important evidence, and as such was submitted to the Journal of the A. M. A., but was declined. It was then sent to the New York Medical Journal, it being the periodical with the next largest national circulation. It was, of course, promptly accepted by that journal and appears in its current issue. However, it does not go to all of the members of the A. M. A., who comprise the jury in this case. As the Journal of the A. M. A. is not available to reach them, I am requesting that you kindly publish the article as the only means of reaching all of the members in California.

Thanking you in advance for this kind co-operation, I am,

Very sincerely,

CHARLES A. L. REED.

The California State Journal of Medicine will hereafter and until further notice be edited by an attorney-at-law—Philip Mills Jones. This announcement should be followed by something appropriate about Jones and a bar, but we are quite unequal to the occasion. May he make as great a success at the practice of law as he has at the practice of medicine.

We received a very attractive booklet from Parke, Davis & Company, a Jubilee Souvenir of the anniversary of their "Fifty years of Manufacturing Pharmacy and Biology." We congratulate them on their enviable record for square dealing and trust the coming years will be filled with profit for them and continued cooperation with their hosts of physician friends.

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EDITORIAL

HEMORRHOIDS IN THE BIBLE.

While Leprosy, Plague and Palsy are often mentioned in the Bible yet the fact is almost forgotten that, in the first chapter of Samuel, Hemorrhoids is twice mentioned as emerods. The latter term was used for this disease during the time of James I.

"But the hand of the Lord was heavy upon them of Ashdod, and he destroyed them, and smote them with emerods, even Ashdod and the coast thereof. . . . And it was so, that, after they had carried it about, the hand of the Lord was against the city with a very great destruction: and he smote the men of the city both small and great, and they had emerods in their secret parts."

In this day and age hemorrhoids is—as in those ancients days—the result of sin, but today it is a sin of omission. With a properly constituted anti-constipation diet and common-sense hygienic precautions this painful affliction

would disappear from the face of the earth.

RADIO-PARAGRAPHS.

There is a vast difference between taking x-ray pictures and making x-ray diagnoses.

A good x-ray diagnosis cannot be made from a poor radiograph.

The modern physician does not treat obscure gastro-intestinal lesions without the aid of radiography in diagnosis.

In lesions of the lungs, radiography substitutes certainty for uncertainty in a large percentage of early cases of tuberculosis, and gives a much clearer and exact record in all cases than is otherwise possible.

Radiography may not supplant many other methods used in diagnosis, but it is an invaluable supplement to them.

Radiography has shown that there are more cases of aortic aneurysm demonstrable during life than had previously been recognized, and that many

of the cases that come under treatment early do remarkably well.

Even in the case of a poverty-stricken patient, it is not safe for the surgeon to rely upon a single radiograph of a fracture.

Roentgenization of cancer cases is important before and after operation.

Roentgen therapy has saved the life of many an inoperable case of cancer.

X-Ray diagnosis and therapy are rapidly enlarging their fields of usefulness, so that it is difficult for the physician to keep up-to-date regarding them.

Did you ever experience the soothing effect of the x-ray in sprain? Try it.

Occupying offices in downtown skyscrapers is not ideal for doctors, especially is this so today when it is almost impossible to find parking place

for an automobile and then only for twenty minutes. Drs. Edward M. Pallette, Thomas Chalmers Myers and Hiram Bradbury Tebbetts have led the way by constructing a beautiful two-story office building at the corner of Fifteenth and Figueroa streets; 1501 South Figueroa is the number. Dr. Harley E. MacDonald, carrying out the same idea, has equipped a building for his offices at the corner of Sixteenth and Hope streets, 1521 South Hope

“McKinley and McKinley,” Security Building, means Judge McKinley and son, the latter (Wilfred) having recently graduated with honors from Harvard Law. The Judge has always been such a loyal friend of the medical profession that we all heartily congratulate him on the accession of a worthy son as a partner.

EDITORIAL NOTES

Dr. Ralph Newcomer, formerly of Idaho, has located at Pomona.

For Sale: A Tycoos Sphygmomanometer in good condition. For particulars phone A2223 or Main 2223.

Wanted—Test case, Perimeter Ophthalmoscope and eye, ear, nose and throat instruments. Address P. O. Box 1958, Los Angeles.

Dr. Albert W. Moore has devoted several weeks to a tour of various eastern surgical clinics with an eye particularly to the latest in bone surgery.

Dr. F. Zarraga, 143½ South Broadway, a recent addition to the profession of Los Angeles, was formerly a prominent physician in the City of Mexico.

Wanted—By trained office assistant, position in physician's office, stenographer and bookkeeper; references. Call West 1241. Address 1506 Arapahoe Street.

Dr. Rollin French will reach home December first after spending three months in eastern hospitals. Two months of his time was at the New

York Post-Graduate Hospital, where he got down to real hard, close work.

We note that the Cincinnati Lancet-Clinic, one of our oldest medical weeklies, is to be suspended at the end of the year. This follows with remarkable promptitude the announcement of its being EDITED BY MARTIN FISHER. Possibly it was killed by excessive modesty.

THIS IS THE PLACE you have been looking for. Quiet, restful, homelike place for invalids and convalescents. Family cooking; special attention to diet; cheerful atmosphere; large, sunny home among oranges and flowers. Not a hospital or sanitarium. For reservations address Mrs. E. C. Miller, Alhambra, Cal.

On account of going East for post-graduate work and to visit relatives, I desire to dispose of my practice. A good opportunity for a live, energetic man. No real estate to sell. Only furniture and fixtures of 10 rooms, part used for hospital. For particulars ad-

dress Dr. S. Pinniger, Tracy, Cal., San Joaquin Co.

For Sale—New fireproof general hospital in prosperous Southern California town near Los Angeles. Capacity 35 patients. Very complete new building, never occupied. Great bargain and favorable terms to right party. Address SECRETARY, P. O. Box 476, Los Angeles, California.

The commanding form of Dr. Byron Stookey is again in our midst. After graduating at Harvard Medical, one year in the Massachusetts General Hospital and fourteen months as a member of the "Harvard Unit" with the British army, Dr. Stookey has located his offices in the Walter P. Story Building, where he will limit his practice to surgery.

Major C. W. Decker, M.D., commander First National Field Hospital at Nogales, after making a record that has been highly commended by the Regular army officials, has returned to his offices in the Marsh-Strong Building. Major Decker made a great sacrifice in thus leaving his practice for several months and his colleagues and friends are very glad to see him safely back.

Dr. E. S. McKee, of Cincinnati, died last month at Quito, Ecuador, South America, of malarial fever. The Doctor had left Cincinnati in search of relief from hay fever, going first to North Carolina and then to South America. He had traveled extensively, but had heretofore avoided South

America in his travels because of his fear of malaria. The Doctor was quite a prolific and entertaining writer, and made many excellent contributions to medical literature. For a number of years he was associated with the Medical College of Ohio, in the Gynecological Department, where the writer had the pleasure of working with him for two years. It speaks well for him that he was best liked by those who knew him best. He was 62 at the time of his death, and is survived by two brothers living in California.

Dr. C. A. L. Reed recently had a "lady" call at his office and try to blackmail him to the extent of twenty thousand dollars. The Doctor's offices are equipped with a dictaphone call service, and upon her first visit the would-be blackmailer talked both to Dr. Reed and unwittingly through the dictaphone to Dr. Reed's stenographer in another room. Upon a second visit there was a detective closeted in the room and two stenographers listened to the conversation via the dictaphone, while Dr. Reed apparently acquiesced to the demand that he pay seven thousand dollars at once, and thirteen thousand additional before the first of the year. The Doctor accompanied the "lady" to his auto and helped her in very gallantly, where she was properly taken care of by a detective in the machine. The driver was also a man from police headquarters. Doesn't this editorial sound very much like an ad for the dictaphone? Wish they would pay for it.

BOOK REVIEWS

PHYSIOLOGICAL CHEMISTRY. A Text-book and Manual for Students. By Albert P. Mathews, Ph.D., Professor of Physiological Chemistry, University of Chicago. Second Edition, Illustrated. William Wood & Co., New York. Price \$4.25 net.

The size and importance of the subject of Physiological Chemistry is

brought more forcibly to the mind after perusing this most excellent text-book by Mathews; indeed he says that one can be personally familiar with but a small part of so large a subject. He has avoided in the work the expression of opinions, preferring to give definite

experiments so that the reader may judge for himself.

The foods are given most thorough treatment and discussion.

Each tissue substance as Brain (called the "Master" tissue)—blood muscle, bones, cartilage, etc., is studied in its physiological manifestations.

A chapter devoted to the widely studied Endocrine glands is a valuable adjunct.

The equipment of a laboratory for the study of Physiological Chemistry is essential to the student, who will find here the latest apparatus for it.

The modern thought about living matter (is not all matter living?) is well exemplified in Mathews' statement on the general properties of living matter. "Living matter is a combustion engine, with cylinders and connecting rods of molecular dimensions and provided, possibly, with an electrical sparking device not so dissimilar in principle from that of an internal combustion or explosion engine," in short an automobile.

THE CLINICS OF JOHN B. MURPHY, M.D., at Mercy Hospital, Chicago. Edited by P. G. Skillern, Jr., M.D., of Philadelphia. October, 1916. Published Bi-Monthly by W. B. Saunders Company, Philadelphia and London.

THE RED BOOK OF EYE, EAR, NOSE AND THROAT SPECIALISTS. Containing the Names and Addresses of Medical Specialists in Diseases of the Eye, Ear, Nose and Throat for the United States and Canada, Arranged According to States and Provinces—Ophthalmological and Oto-Laryngological Societies—Medical and Post Graduate Schools and Colleges—a Selected List of Books Pertaining to the Eye, Ear, Nose and Throat and Other Valuable Information Never Before Collected and Compiled in One Volume. Also an Index to the Names in this Book Arranged Alphabetically. Second Edition, 1916. Price, \$3.00. Published by Lionel Topaz, 35 North Dearborn Street, Chicago, Illinois.

When you want to refer a case to a specialist in some other town, and you do not know who the reputable specialists are, reference to this handy volume will solve the problem for you.

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There are a number of so-called antiseptic soaps. Probably the most generally serviceable of these is Germicidal Soap, formula of Dr. Charles T. McClintock, which has been not inaptly designated "the soap of a hundred uses"—a soap made from pure vegetable oils and containing the powerful antiseptic mercuric iodide. As indicative of the germicidal power of this soap it may be said that a solution of it containing one part of mercuric iodide in five thousand parts of diluent will destroy pus organisms in less than five minutes. It is undoubtedly the most available antiseptic for the general practitioner. There are no solutions to carry. The soap is always ready for use. It does not stain linen or tarnish polished instruments.

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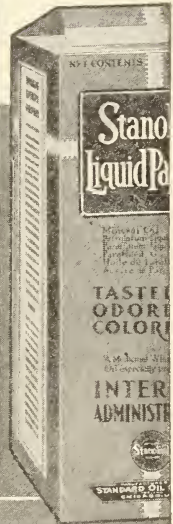
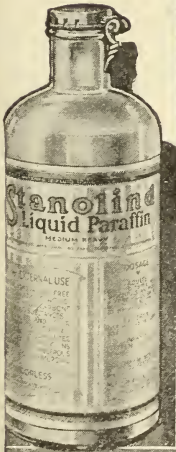
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STRAINING AT STOOL.

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Since defecation is a necessary function, and cannot be suspended, it would seem that the best remedy for the difficulty of defecation would be to supply the lubrication that is often lacking and thus bringing about the necessity of straining at stool.

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EARLY LOS ANGELES MEDICAL DAYS.*

BY WM. LE MOYNE WILLS, A.M., M.D., OF THE CALIFORNIA STATE BOARD OF HEALTH.

As a contribution to an Evening of Reminiscences of Los Angeles, I have been asked to speak of medical men and things in the early days. Of what preceded my coming, I can only speak by what I learned from the medical friends and others of the pioneer Americans who came hither in the early forties and thereafter.

I first saw Los Angeles in March, '76, having been sent west from college because of illness there; came down the coast from San Francisco on the old sidewheeler "Orizaba" to San Diego and Los Angeles and spent a month in seeing the country hereabouts.

Pasadena was a hamlet called Indiana Colony and Orange Grove avenue, which was its principal street then with its two live oaks in the center, was a one-tracked wagon road, with orange trees on each side as thick as one's forefinger. The steamer landed you at San Pedro by lighter and a train brought you to Alameda and Commer-

cial streets, where the railroad depot was. While in Los Angeles that year, the opening of the S. P. R. R. east was celebrated by a Sunday-school picnic to 29 Palms, 108 miles east, and I went with an acquaintance on that excursion to see the desert. Another time I went to San Bernardino, by train to Colton and San Bernardino by stage, and rode about the valley on horseback. Like thousands of others since, being enamored of the country, I came back, after completing my studies, and in two days in August, '83, decided to cast in my lot with this historic pueblo of twenty thousand inhabitants, rapidly growing towards a city.

The Pico House in the Plaza was the best hotel, the Temple Block the center of things, the Baker Block the finest edifice and First street the limit of business southward. The Nadeau House was just built, the postoffice in the Odd Fellows Building across Spring street above First, and when I rented an

*Read before the Sunset Club of Los Angeles, September 29, 1916.

office from Dr. Widney on First street, I was thought to be farther away from business than Ninth street was five years ago.

Conditions were very primitive medically; there was no such thing as a **hospital**, the nearest approach being the Infirmary, the then Sisters Hospital, near the S. P. River Station conducted by the Sisters of St. Vincent de Paul, and the County Hospital on the Mission Road. Such a luxury as a trained nurse was unheard of and all treatment, even most operations, done in private houses. It is hard now to realize the difficulties the early physicians had to cope with compared with the present. Whatever success they obtained was largely due to greater personal effort on their part—the hardier men and women with greater resistance for patients—and also perhaps because the dangers of bacteria and germs had not been discovered by Pasteur and applied by Lord Lister and communicated to a happy and ignorant world. People died after best efforts to save them from sepsis, peritonitis and what not and the world was happier because it did not know what coccus or germ was responsible. Now all is changed—a culture is made, serum squirted into you or an X-Ray taken—you know just how many hours you have to live before passing on. Who says the Idle Forties to Seventies were not preferable and the saddle horse better than the railroad, the fast flying automobile and aeroplane!

The outstanding figures in the medical life of Los Angeles in 1883 were Dr. Richard S. Den, Dr. John S. Griffin, Dr. J. P. Widney and Dr. Henry S. Orme among the older residents and men. Then came in priority of settlement here, Drs. K. D. Wise, Joseph Kurtz, Henry Worthington, Walter Lindley, Hubert Nadeau, F. T. Bicknell, H. H. Maynard, W. G. Cochran, Ross Kirkpatrick, George W. Lasher and others. Of these I shall speak especially and at length of four, who by

their time of settlement here and their lives and works divide the early medical history of Los Angeles into three periods, namely Dr. Richard S. Den, the Irish doctor of the "Dons" in the "Idle Forties" before the American occupation; Dr. John S. Griffin, ex-U. S. army surgeon, who came with General Kearney's Dragoons across the plains to this coast in '46 and practiced here during the early years of the American incursion; Dr. Joseph P. Widney, another ex-U. S. A. surgeon, and Dr. Henry S. Orme, ex-Confederate army surgeon, both of whom came to the town in '68 when it was beginning to lose its Mexican characteristics and take on the appearance of a more enterprising American town and who were identified with the life of the city from '68 down to modern times. These are the eras which I think will be more interesting to you than more modern medical history with which you are more or less familiar. The physicians I have mentioned other than these four most of you know or at least know about.

Dr. Richard S. Den was born in Ireland in 1821. After receiving a thorough education as a physician, surgeon and obstetrician, he sailed as surgeon on a ship to Australia in '42, came to Mexico and Santa Barbara, where he had a brother, Nicholas Den, and settled there in 1843. Having come to Los Angeles professionally, he was petitioned by the leading citizens both native born and foreign, to come here to reside, which he did in 1844, remaining here until his death.

Dr. Den was a typical, rubicund Irish gentleman of the old school, a veritable character out of Dickens, always wore a black stock and high hat and brown frock coat, and he jauntily rode a black saddle horse with Spanish bit, saddle, tapideros and all appurtenances. Sitting a little to one side, swaying gracefully to the horse's swinging lope, he was to be seen every day on the street

making his calls, always on horseback. He had his office and home in the Baker Block and was in great demand among the pioneer families of Mexican and American descent. He was a bachelor and very dignified, almost pompous, in his manner and had a delicious rich Irish brogue. Always most courteous, he allowed no liberties or familiarities, would have fallen dead had anyone slapped him on the back and called him "Doc." When quizzed by curious people as to what was the matter with So and So, he would reply with great emphasis "He is sick." "What are you giving him?" if one ventured so far. "Medicine, of course!" If a patient would ask "What are you giving me?" he would haughtily answer "That is my business," which settled the questioner and did not give away his treatment. He used to ride from fifty to one hundred miles often so greatly was he in demand among the wealthy California families, and great were his fees for such services. He was especially courteous, dignified and ethical with medical men, particularly so in consultations.

I well recollect the old gentleman going down by train in '92 to the San Diego celebration of the landing of Juan Cabrillo. He told me he had not been there in thirty years and was uncertain as to trains and how to get to his hotel. I took pleasure in carrying his great trunk-like valise, too heavy for him, and put him in a carriage and escorted him to the Coronado Hotel, where he had a room engaged. He was profuse in his acknowledgments for the trifling attention, which I considered his age entitled him to and which it was a pleasure for me to extend to a delightful old gentleman.

Dr. Den kept his horse at the same stable across from the Baker Block, as I did mine, and we had the same old Irish hostler care for our horses. I used to see his horse often late in the forenoon, saddled, champing his bit im-

patiently, throwing up his head and rolling the ring of the bit on his tongue restlessly. I once said, "Tom, why don't you unbridle that horse until he is wanted?" Tom replied, "You don't know Dr. Den. He has told me often—'Tom, I want my horse saddled and bridled at eight. If I don't come for him, it's none of your d—d business.'" So Black horse was always ready at eight.

This old man, as he grew older, did less and less business and finally died in his sleep—was found with a smile on his sweet old face in the morning. Thus passed, after a useful and successful professional life, loved and respected by all who knew him, the last doctor of the Old Régime, his like never to be seen again. He came to Los Angeles when a Mexican town of perhaps three thousand, saw it grow to be a city of one hundred thousand with all its changes and improvements before he died in 1895.

Dr. John S. Griffin I knew very intimately as a patron, friend and patient. Another most lovable, delightful man of the old school, well nigh extinct, who loved the society of young people and thereby kept young in spirit himself. Dr. Griffin was about giving up active practice when I came here, and was good enough to ask me to assist him and to send me to his patients. Being a graduate of the Univ. of Penn. Medical Department of 1837, he took an interest in me, a later graduate of the same school. He was born in Virginia in 1816 and after practicing in Louisville, he entered the U. S. army as surgeon and served in Florida and on the southwestern frontier. He came to California with Gen. Kearney across the plains in 1846 and he told me that instead of coming through the San Gorgonia Pass, they crossed from Yuma to San Diego and came up the coast, and in the ravine near New Calvary Cemetery the First Dragoons, Kearney's command, armed with carbines,

met and defeated the Mexican lancers, which was the last fight for Los Angeles. Dr. Griffin went north to Benicia, the then capital, but soon resigned from the army and returned to Los Angeles in January '47 and spent the rest of his life here.

He did not return east to fight for the South in the Civil War, but had all the antipathy to the North that his birth and traditions entitled him to, and always spoke of his northern brothers as "DammYankees"—all one word. I have heard a good story illustrating his humor. With Don Benito Wilson (for whom Wilson's Peak is named) he owned the San Pasqual Rancho, where Pasadena now stands. One day in '74 or '75 he met Mr. Wilson and said, "Wilson, I have gotten the best of the Dammyankees this time, I have sold that old sheep ranch to the Dammyankees for nine dollars per acre." Mr. Wilson replied, "Griffin, that is robbery."

Besides being a fine physician and surgeon, he was a public spirited citizen, one of the founders of the City Water Co. in 1868 and its first president. He bought two thousand acres east of the river for fifty cents per acre and he and his nephew, Hancock Johnston, laid out East Los Angeles. He practically gave Eastlake Park to the city and it should have been named for him. Fred Eaton was his wife's nephew and became engineer of the City Water Co. and Wm. Mulholland grew up under Dr. Griffin's presidency of the water company and has become our great water engineer.

When I first knew Dr. Griffin he had an office next the Childs Opera House on Main street near First, which he used until he gave up practice in '87 or '88 and moved to a beautiful home he built on Downey avenue, the corner of Daly street. Dr. Griffin used to guy and rally me about our Crossroads Medical School, founded in 1885 and of which I was one of the pioneer faculty,

until we had graduated several classes and our graduates were doing us and themselves credit, and then he frankly acknowledged the good work his former partner, Dr. Widney, and the faculty were doing for Southern California.

I can see the dear old white-haired, white-bearded, handsome face with the black slouch hat and hear his deep voice and infectious laugh and hear the thump of his crooknecked, heavy cane. He was jolly, high tempered and peppery and the best, most unctuous swearer I ever knew. His swearing was mellow and emphatic, strong adjectives, not profane. I was telegraphed to go to San Jacinto to see him in 1891 when he was sick. At first he was pleased to see me—"Hello, Wills," in a weak, pleased voice—then he roared—"Hancock had no business to send for you and by G—, you can't use any of those instruments on me" (seeing my bag.) He immediately got better and I left the next morning without doing anything for him. He took me to see my first prize fight in the old Merced Theatre near Pico House and always went to see such exhibitions. He was never so happy as when giving younger people pleasure and his grand-nephews were his companions.

Dr. Griffin was most courteous and polite to women, had a grand manner, raising his hat impressively, "Your most obedient, Madam," and it was genuine. He was the youngest old man in the medical profession I have ever known other than Dr. Beverly Cole of San Francisco. Dr. Griffin told me he whipped a well known man in this town in front of his own father for calling him a liar, yet he was as tender as a woman in the sick room or with ladies and was loved by all who knew him.

Several of this club's members will recollect a dinner party given in honor of Dr. Griffin by me to celebrate the fiftieth anniversary of his settlement in Los Angeles, January 31, 1897. I had operated on an Italian cook at the

County Hospital who wished to show his gratitude by giving me a dinner and so it celebrated the event mentioned. It was given at the Roma Hotel, an Italian boarding house opposite the Kerckhoff-Cuzner lumber yard on Alameda street. The place was not attractive, the utensils crude, but the dinner was excellent and the spirits, of both kinds, suited to the occasion and the guest we honored. The dear old man lived only a year and a half after this anniversary of his settlement in the city he helped to build.

Dr. J. P. Widney, still living, was a man of an entirely different type, studious, very religious and scholarly and the broadest minded and most liberal religious man I have ever known. He came to Los Angeles in 1868, having been a surgeon in the U. S. army in Arizona, and took an active part in the medical and educational life of the town. He knew that several low standard medical men intended starting a diploma mill here, à la Buchanan in Philadelphia, and so determined to forestall them with a good, high standard medical school. I was fortunate enough to have an office in his building on First street near Spring, and one day in the spring of 1885 he told me of his plan, and I replied that I saw no field for such a school. However he convinced us whom he called together of its necessity, founded the school, gave the use of his building on Aliso street, and the faculty composed of the best men in the city opened its first session in September, 1885. This college was the fourth in the United States to insist on a three-year course of medicine and from its inception almost has been a member of the Association of American Medical Colleges, subscribing to all its requirements and endeavoring always to raise the standard of medical education and attainment in the great Southwest. The results have justified Dr. Widney's foresight and faith in the growth of this section. Dr. Widney

gave his whole time to the planning and the active work as dean and professor of medicine of the school and so arranged its charter, that the property of the school was kept separate and distinct from that of the University of Southern California, under whose charter the medical school operated as a department; and so in later years, our school severed its connection with U. S. C. and joined the University of California for financial and teaching reasons.

Dr. Widney was for a time President of the University of Southern California, but gave up that position and took orders in the Methodist Episcopal Church and established the Church of the Nazarenes. Afterwards he and his wife founded a mission on Santee street near Ninth and taught in it themselves. Now, since his wife's death, he and his sister live on Avenue 39 and he conducts a little church, preaching himself and devoting himself to literary work.

Dr. Widney is a fine classical scholar and writer and has written a number of books. His "Race Life of the Aryan People in Europe and America" in two volumes is recognized as a classic and is an exhaustive and most interesting story of the wanderings of the white race. Another book of Dr. Widney's is "The Climate of Southern California," printed many years ago, an authority, which had a large sale. It was a scientific treatise on the wonders of this southern country, then so little known. Dr. Widney has served on many boards, city, county and state, and held many positions of honor. Thus Dr. Widney has given much to the upbuilding of this section by his life and his works, medical, literary and religious.

These two men, Dr. Griffin and Dr. Widney, diametrically opposite in temperament and other attributes, were partners or years and devoted friends, each revering and respecting the other, so very different in character.

They of all the medical men before or since, in my opinion, have had more to do with the business and educational progress of Los Angeles than all others. Their successors have followed in the paths of these pioneers. It has been one of my greatest heritages to have been the assistant and helper of these two great men.

Dr. Henry S. Orme came to Los Angeles after the Civil War, he having graduated in New York in 1861. He became a surgeon in the Confederate army, serving throughout the war and settled in Los Angeles in 1867, where he practiced until his death a few months ago. He was prominent as a physician and was a high Mason. Dr. Orme was our city's first health officer, elected in 1868 during an epidemic of smallpox. He was always much interested in sanitation and hygiene and served in many positions of honor. Was President of the State Board of Health, President of the State Medical Society, member of the American Medical Association, and many times went east to attend its meetings when an eastern trip was a matter of weeks. He was a member of all local medical societies and Professor of Hygiene in the Medical Department of the University of Southern California from its beginning in '85 for more than twenty years.

He was always courteous and the friend of the younger members of the

profession and polite to newcomers. Dr. Orme was active and wonderfully energetic and practiced his profession until his death, believing it was better to wear out than to rust out. He was one of the first doctors I met in consultation and his treatment of me was such as to make us good friends from that day on until his death.

The time allotted to me will not permit of more than the mention, already made, of the other men who were prominent in the medical life and work of the early eighties. Most of them are living, or were until a few years ago, and you know them or about them. It is surprising how many doctors came here about the same time between 1883 and 1890. Most of our Medical Sunset Club members came here in that period. The changes and improvements which we pioneers of the 70's and 80's have seen and taken part in bringing about, have been commensurate with and have kept pace with the phenomenal growth of Los Angeles, from the town of 20,000 to the modern city of half a million inhabitants of today. What would have been then considered medical luxuries, such as fireproof hospitals, trained nurses, specialists, etc., are now expected and demanded by all, high and low. It is only by comparison that we can appreciate how rapid and how great has been the medical progress of the past five or six decades.

USE AND ABUSE OF ARCH SUPPORTERS.

BY CHARLES LEROY LOWMAN, M.D., LOS ANGELES.

It is not my intention to enter into a technical discussion of arch plates, but chiefly to call attention to the careless and ignorant manner of prescribing stock plates such as are sold at shoe stores.

The conditions for which plates are so commonly used are the following: flat-

foot, congenital and acquired; broken arches, weak feet, foot strain, pains through ball and instep, sensitive heels, etc.

In order to make clear to you the reasons why great damage may be done by the use of such plates it will be

necessary to consider the statics of the foot and leg.

The normal weight or gravity line in the leg is a line dropped from the anterior superior spine of the ilium, through the patella, and should fall through the middle of the ankle joint, and into the foot just to the outside of the head of the first metatarsal. We may allow a moderate amount of variation in women, letting the last mentioned point be further in, because of the more inward inclination of the thighs, which throws the weight line more toward the median line.

In the treatment of pathologic conditions affecting the mechanics of the foot and leg it is very essential that a comprehensive view of the situation be taken, and that the foot be considered and treated, not simply as a foot, but as the foundation of the body. If the weight of the body falls through a certain weight line, it is obvious that unless it falls correctly into the foot, so that the bones of the foot take the weight as nature intended, it will fall otherwise. The usual deviation, of course, is inward, throwing the weight on the ligaments and muscles which pass into the foot around the inner malleolus and under the scaphoid, making them do work which the bony column should do.

Various conditions are responsible for diverting this weight inward. (1) Any condition of unbalanced muscular pull in the foot, such as relaxation of the adductors, with subsequent adaptive shortening of the abductors. (2) Spasm or over action of the peronei, lifting the outside of the foot and throwing the load inward. (3) Faulty postural conditions, such as habitual out-toeing, which, because of the single antero-posterior action of the knee and ankle forces the thrust forward and inward, thus favoring or causing a valgus position at the ankle. (4) Faulty leg conditions, for example, bow-legs, in which the tibia is bowed and

rotated outward. This forces the weight down through a curved lever across the ankle and gives a valgus position to the foot. (5) Knock-knees. In which the position of the knees forces the thighs inward, displacing the gravity line. (6) Inward thigh rotation, which stretches the outward thigh rotators and causes the long leg lever to act on the astragalus like a socket wrench, twisting it inward. (7) Weakness of the ligaments and muscles following exhausting fevers, as in tuberculosis, typhoid, influenza, etc. (8) Occupations: continued standing, especially in the out-toe position by bench workers, motormen, cooks, and waiters. (9) Sudden increase in weight out of proportion to the strength of the muscles. Increase beyond a point at which nature has been holding or tolerating an otherwise unbalanced condition; or increase suddenly after an exhaustive disease such as typhoid; or, as we frequently see in fat children at puberty. (10) Pregnancy: during which time there is both increase in weight and increased strain on the balance muscles throughout the body. (12) Faulty shoeing. (a) Bad positions directly attributable to bad action of shoes, either from a wrongly shaped shoe or a badly fitted shoe of good shape. (b) Shoes supplying inefficient foundation in conditions which need a restful easy grip on the ground, for example, following a fracture in the leg, or an old sprain, or after an operation if the patient is allowed to wear the same shoe as before the strain, the weakened condition of the muscles cannot stand the overload and become unbalanced in their action. (13) Bone diseases: Rachitis and other diseases of mal-nutrition. Any or several of these factors combined may enter into the production of the ordinary valgus or acquired flatfoot, and the list could be greatly lengthened but the above items are sufficient to illustrate the point.

A very high percentage of the

patients presented for treatment, but to the orthopedist and to the general practitioner, are not actually flatfooted, nor have they even broken arches, but merely an inward deviation of the leg, either laterally or rotated inward, with a condition of muscular lack of balance in foot or leg, or both, with or without the symptoms of pain or strain.

For the prevention and correction of these conditions a support of some kind is often necessary as a help. Arch supports in themselves, except in unusual cases, should be passive, not active. All arch supports of any make are vicious in certain respects, viz:—they weaken the muscles and the condition is worse in the end than at the beginning if the supports alone are depended on for a cure. The length of the leg lever above the ankle varies from fifteen to twenty-five times the distance from the fulcrum, i. e., the ankle, to the ground. A flat, or nearly flat, piece of metal under the foot and not attached to it is unable, except in a mild degree, to influence the action of the long lever above, through which falls the body weight, often a heavy one. So that the question of neutralizing the effect of a faulty leg line on the foot must begin with shoe adjustment as a foundation from which the plate acts.

The heel of the shoe should be raised from one-eighth to three-eighth inches higher on the inner border thus helping to shift the weight outward and making it fall on the outer border of the plate. This aids in tipping the inner flange of the plate upward, giving a corrective thrust. A faulty plate is bad at any time, a good plate in a bad shoe or a good shoe badly adjusted, or not adjusted at all, is nearly, if not equally as bad. A good plate in a proper shoe but used as a prop, where exercises are needed, is comparable to putting an arm needing exercise into a cast.

Just a word now regarding the foot as a foundation. It is half a dome,

with three main ribs or lines which act as the struts or braces. The outer border should stay close to the ground and the inner border be high and slightly concave outward, or at least be outside a straight line drawn from the heel to the toe. Consequently, an arch prop, to be efficient must be able to induce the foot to take this position, and must have certain foundation points so placed that it cannot tip out of place and cause the foot to assume any undesirable position.

The common type of shoe-store or stock plate as sold and adjusted by shoe dealers, chiropodists, brace-makers, and I am sorry to say some doctors, possesses scarcely a point in its favor from a mechanical and clinical standpoint. The only thing in its favor is that it "gives some relief." This evidently is all that any of the parties concerned usually want at the time. However, the relief gained is not because of the efficiency of the plate, but because of the fact that the sore or tired foot temporarily responds to the application of a splint, for such is all it is. The same result can be attained by any piece of padding or suitably padded stiff material. By this type of plate the foot is affected in two ways: (1) Limitation of motion in the many joints of the foot. (2) The fact that the rise in the plate supports the sagging arch somewhat and thus gives temporary relief. This keeps up a certain demand for stock plates. However, fully eighty per cent of the foot cases presenting themselves for treatment with one accord say, "We have used these store plates and for a while got some relief, but lately we have been much worse" or "Now they don't help any" or "They make me worse" or "I can't wear them without a lot of leg-ache or knee pains, which I didn't have before," or "My little girl's ankles bulged in a little and we had these plates recommended, but lately she is having growing pains in the

knees," or more backache, and other remarks too numerous to mention.

We do not have to go far for the explanation: You cannot correct a foot in valgus by a plate that lists into valgus. These plates invariably, when weight from above falls on them roll in, and the more the weight line is deviated the further inward on the inner flange of the plate will the weight fall and thus the more it will tip. The worst feature of the tipping is that while the foot is rolled inward, the outer border is lifted upward, and there is consequently an adaptive shortening of the peronei or abductors of the foot, at the same time the worn out tired adductors are being all the more stretched, and the result is just the opposite of what is wanted.

The damage is not so much to the foot as to the structures above, especially the knees, hips, sacro-iliac joints and the back. These are made to work in faulty lines with subsequent strain and inflammation, and the body balance as a whole is materially affected because of the disturbance at the foundation.

Other faults in the stock plate are, that it is not made for any given foot, and has not a correct or adequate transverse arch. When it is put on a patient suffering with anterior arch conditions, such as Morton's toe, bunions, callosities, etc., not only does it do no good, but does harm. Shoe clerks and chiropodists are doing the race just as much, and oftentimes more harm, by prescribing for foot diseases or deformities than are the quacks and other illegal practitioners in other lines. The law specifically states who shall treat diseases and deformities, and unless people ask for such supports the dealer should be otherwise prohibited from selling them. These plates are stamped out and shaped by machinery, made cheaply, sold at big profit, and usually clerks are allowed a bonus on all they sell; consequently, they urge any and every one

with any sort of a symptom in the foot to try one. There are many varieties, some slightly better than others, but all are apt to do permanent damage, even though at first they have been of temporary relief. Worst of all when used under a child's foot they are an active agent in producing the very deformity which it is hoped to correct.

It is very easy for you to infer now what points a good plate should have—just about the opposite to what the store plate has. They should always be made for the foot that is to wear them, the type varying with the need. These which I present vary in type but have certain things in common. They induce a correct position of the foot in relation to the weight line, and also have a local effect on the various parts of the foot when pressure is to be applied, for instance, raising the metatarsal heads, the scaphoid, the anterior end of the os calcis, etc.

A few simple rules may be of help to some of you and may save some pairs of sore feet lots of trouble.

Do not call every pain in the foot rheumatism or broken arches.

Do not study one segment of the body alone, but study the affected part and its relation to each and all of the other segments, especially as to alignment and body balance.

Do not rely on an arch support as the sole curative factor, it is only an adjunct. Attend to the shoes first.

Remember that an arch support which stands on end in a high heeled shoe is not very effective.

Have great respect for a sick foot; you may have one yourself some day. Don't condemn it for life to any kind of a plate without careful trial of other means and as Dr. Lasher used to teach us, "If you can't do a foot any good, don't do it harm."

C. L. LOWMAN, M.D.,
Chief of Orthopaedic Clinic,
L. A. Branch U. of Cal.
Los Angeles, Calif.

THE DIAGNOSIS OF THE INTERNAL SECRETORY DISEASES.

BY HENRY R. HARROWER, M.D., F.R.S.M. (LOND.), LOS ANGELES, CAL.

VIII.

Internal Secretory Disturbances of the Gonads.

There are numerous diseases of the gonads, or essential sex glands, which are discussed in any work on surgery or gynecology. The infections and tumors of the testes and ovaries need not be considered here. There are, however, a number of symptoms—complex which result from some derangement of the endocrine functions of the gonads, and to these it is proposed to call attention.

As all know the ovaries are a far more frequent source of disease, functional or organic, than the testes, though each gland is subject to a number of affections. Let us first devote our attention to the female gonads.

Preliminary Considerations.

The biochemical basis of femininity is more important than either the psychological basis, or that dependent upon the nervous system. The hormones transcend in importance all other factors in the regulation of the chemistry of the body and, therefore, the chemistry of the reproductive organs, hence derangements in the glands of internal secretion, particularly those under discussion for the moment, spells deranged metabolism, disturbed nutrition and altered sex conditions.

The whole subject is handled in a masterly and most interesting fashion in the recently published book "The Sex Complex"* by my friend Dr. W. Blair Bell of Liverpool, from which

*"The Sex Complex;" A Study of the Relationships of the Internal Secretions to the Female Characteristics and Functions in Health and Disease, by W. Blair Bell, B.S., M.D., Lond., Gynecological Surgeon to the Royal Infirmary, Liverpool; Hunterian Professor in the Royal College of Surgeons, England, etc. New York. William Wood & Son, 1916. Pp. 233.

a few short quotations will be made later. The least that I can say about this book is that it is of fascinating interest and much practical value to the reader.

For convenience the experimental evidence which has established the almost universal belief that the ovaries produce one or more internal secretions, must be omitted, though it may be stated that the ovary presides over genital development and in a large measure is concerned in bringing about the changes in feature, form and function which accompany the commencement and cessation of sexual life—puberty and the menopause—as well as other well known changes in the interim.

From the standpoint of endocrinology, and especially the diagnostic aspect of it, the ovaries are subject to three forms of functional disorder: (1) Deficient secretion; (2) excessive secretion, and (3) perverted secretion. The results of these will be considered briefly and the essentials of their diagnosis outlined here.

Ovarian Insufficiency.

Hypoovarium or ovarian insufficiency may be spontaneous in origin or it may be an acquired condition; that is to say the change may be initiated sufficiently early to prevent the normal development and growth dependent thereon; or, on the other hand, disease of the ovaries may supervene after ovarian function or maturity has been fully established with certain fairly well defined results.

The former condition naturally implies a wider and more fundamental

symptomatology, for the changes of puberty are purely of endocrine origin and the ovaries are among the principal agencies in bringing them about.* The results of early ovarian insufficiency are combined and generally known as "infantilism." The usual findings include delayed or arrested growth of the body as a whole and of the reproductive organs in particular. The breasts may be small and undeveloped, though not infrequently this does not appear to be the case especially when there is plenty of fat in the tissues. The hips are narrow. The pubic and axillary hair is scanty or absent; and the psychic and sensory evidences of sex are diminished in degree or entirely absent.

The later onset of ovarian insufficiency is not accompanied by such well marked evidences, at least as far as physical development is concerned, for obvious reasons; but the functional changes are usually clearly discernible. Since the growth of the myometrium and, in fact, the pelvic circulation and reproductive development are under hormone control, in cases of ovarian insufficiency the uterus may be expected to be infantile (or "senile") and the adnexa undeveloped or atrophied.

Where this is acquired later in life, genital atrophy is to be seen as a shrinking of the internal and external genitalia.* The labia majora diminish and insignificant and may disappear en-

*Though it is well established that the thyroid, thymus, pituitary and adrenal cortex, and possibly others of the ductless glands including the pineal body, exert a controlling influence upon the function of the ovaries and that disturbances of these glands very commonly are reflected in the physiological activities connected with ovarian function. For this reason mistakes have been made in charging to the gonads what is really of more remote origin. Incidentally the aphorism "Monoglandular disease is rare; pluriglandular disorder is the rule," will bear careful remembrance when studying the aspects of ovarian disease.

*See W. P. Graves "Practical Aspects of the Ovarian Secretions," New York State Journal of Medicine, August, 1916. in size, while the l. minora are slender

tirely. The introitus narrows and tends to become valve-like, and the modified vaginal membrane is thin, pale and mottled, later becoming tough and unyielding. The vagina contracts and obstructing bands may be formed, while the cervix shrinks and its lumen tends to close.

Quite the most common clinical evidence of hypoovarism is amenorrhea; and this symptom may be seen in all grades from complete absence to bi-monthly or more widely separated "occasional" periods, and from regular menses with practically no flow (and, often, a good deal of pain and physical discomfort) to irregular and widely separated periods with a seemingly normal amount of menstrual discharge and little or no physical discomfort with it.

The general health may be quite good and in young girls no special attention be paid to the sexual condition until several years after the normal time to mature. On the other hand, malnutrition and, particularly, anemia are usual accompaniments of ovarian insufficiency.

Reflex troubles are often found, the most common among which is headache. Hysteria has been noted many times and "neurasthenia" is often the label improperly attached to hypoovarism or, more properly, pluriglandular insufficiency with ovarian involvement.

With the above changes one would naturally expect to find sterility, and this is the rule (though there are exceptions to it). Indeed sterility may be the only sign of ovarian insufficiency. Repeated early abortions have been seen by the writer in which the cause evidently was not so much defective ovulation or impregnation (syphilis having been ruled out) as a difficulty with the proper implantation of an apparently normal embryo, a function which is now conceded to be made possible through hormone influences, and which, by the way, occasionally may be remedied by suitable organotherapy.

There is an aspect of diminished ovarian secretion in relation to the mentality which may be mentioned. This is the hypoovarium occasionally accompanied by evidences of masculinity or, at least, reduced femininity. This is interestingly referred to by Blair Bell from whose book (p. 207) the following is quoted: "When any of the masculinity-producing internal secretions become abnormally active in women the ovarian secretions are antagonized or inhibited, partially or completely, and the metabolism is directed towards the necessities of masculinity. In such circumstances, with the development of physical changes towards masculinity, the mind becomes less feminine in its outlook. Cases of so-called 'true hermaphroditism' are rare; but there is little doubt that women with a larger share of masculinity than is normal are extremely common. These unnatural individuals are easily detected by the coarseness of their skins, by the size of their extremities, by the ill-development of their breasts and by the assertiveness and aggressiveness of their conversation and schemes. No doubt many of them have hyperplasia of the suprarenal cortices or of the pituitary; and the atrophy of the ovaries when it exists, is secondary to the primary changes in the other organs of internal secretion which are responsible for the development of masculinity."

The Menopause.

Strictly speaking the "change of life" is a physiological hypoovarium—the removal of a chemical factor in the hormone balance to which the organism has accustomed itself for thirty or more years. The organic changes are too well known to require reiteration here and include most of the retrograde changes previously mentioned. The functional derangements accompanying the climacteric are very common, and are a subject of special interest since

they often constitute a form of hypoovarium which responds to ovarian therapy and, too, they are not infrequently brought about prematurely by necessary or unnecessary surgical interference.

The circulatory, sensory and psychic aberrations of climacteric origin include irregular uterine hemorrhage, "flashes of heat," pelvic fullness due to congestion, headaches, fleeting and indefinite pains and sensory disturbances in various localities, irritability, melancholia or depression and the well-known but little understood "neurasthenia." Vasomotor derangements following castration or the menopause may also follow functional ovarian insufficiency due to local disease. These functional disorders of the menopause usually may be treated as hypoovarium with encouraging results.

Hyperovarium.

Excessive internal secretory activity on the part of the ovaries or hyperovarium is not so frequently encountered as ovarian insufficiency. Rarely in early life it may accompany pituitary disease, abnormal thymus atrophy or a pineal tumor and as a result of the disturbed hormone stimuli, the ovaries may commence to functionate very early. Cases are on record where the evidences of puberty were present at five or six years and from a reproductive standpoint, while procreation may not have been possible, at least such cases were rightly classed as "precocious."

For reasons that are not always clear—psychic, functional or organic—the ovaries may produce an undue amount of their internal secretion. The resultant symptoms include menorrhagia (frequent menstrual periods or an excessive flow at proper intervals), sexual or mental supersensitiveness and pelvic pain and a sense of uncomfortable fullness in the lower abdomen. The external genitalia are irritable and the

condition known as nymphomania may be purely of ovarian origin. Hysteria also may be directly due to this disturbance.

The adrenal glands may be excessively stimulated by this abnormal secretory action of the ovaries which accounts for the ease with which such individuals become fatigued and the ultimate asthenia or adynamia so common in certain "ovarian cases." Here, however, it should be remembered that numerous other circumstances may be the cause of adrenal depletion and the consequent asthenia while accompanying other evidences of hyperovarism may really be due to other remote causes.

Cases of functional hyperovarism usually exhibit sexual neuroses, and these results may include masturbation and nymphomania, growing into "sexual insanity."

There is a therapeutic-diagnostic test which is well worth trying in hyperovarism: Functional menorrhagia and other conditions purely due to ovarian excess (not to new growths or to mechanical causes) are often modified by mammary organotherapy. Five to ten grains of desiccated mammary gland given three times a day before meals have controlled the hemorrhage and pelvic uncomfortableness very nicely. At the same time this assists in establishing the functional basis of the disorder. (Parenthetically the internal secretion of the mammary glands exerts an antagonistic action over that of the ovaries, as does that of the pancreas over the secretion of the adrenal medulla, and vice versa.)

One of the chemical results of hyperovarism is especially noticeable in osteomalacia. This lack of lime and softening of the bones is now known to be intimately connected with the glands of internal secretion and particularly the ovaries. Osteomalacia may be brought about directly by ovarian excess (and be remedied very largely by

removal of a portion of the hyperactive glands just as the thyroid is removed, in part, in hyperthyroidism, etc.) In these cases the disordered calcium metabolism is due probably to the abnormal excretion of lime brought about by the undue ovarian stimuli.* This condition is not usual in non-pregnant women as they do not have the great need for lime that is present during pregnancy; but since child-bearing causes a large demand for extra lime, softening of the bones may occur and is not uncommon in Italy, Austria and India. At one time osteomalacia was routinely treated by oophorectomy, but since Bossi, in 1907, first suggested the administration of an antagonizing hormone instead of ovarian removal, adrenal substance has been given with many resulting cures. More recently Blair Bell has directed a series of cases in India, at long distance, and the posterior pituitary principle has been given in osteomalacia with distinct benefit in a number of cases. This seems to indicate that osteomalacia is likely a pluriglandular disorder, the hyperovarism being coupled with hypoadrenia or hypopituitarism. This is undoubtedly the case and indicates, at least, a prospective line of treatment of hyperovarism where ordinary treatment is unavailing and operation inadvisable.

Dysovarism.

The third form of ovarian dysfunction is not unusual and is a form of gonad dyshormonism that really results from deranged cell activities following new growths or cysts of the ovaries. The frequency of ovarian tumors is responsible for the frequency of dysovarism. This condition is differentiable from hyperovarism and the clinical findings are irregular since dysovarism

*Blair Bell has shown by numerous experiments that the ovaries are an important factor in the regulation of the power of the organism to appropriate calcium; and the clinical experiences with osteomalacia seem to prove his contention.

may be accompanied by periods of ovarian excess or insufficiency.

Occasionally there is produced in the ovarian tissue (either in the normal interstitial or luteal cells, or in those of the new growth) a toxic hormone of extreme virulence and in comparatively recent German literature the term "ovarian poisoning" is found, denoting a vicious activity of diseased ovarian tissue with serious remote effects due to the poisons produced there and secreted directly into the blood stream as are practically all the hormone bearing internal secretions. The treatment, of course, involves the removal of the offending tissue.

Dysovarism may be the cause of alternate periods of amenorrhœa and menorrhœgia. Dysmenorrhœa is the rule. Neurotic manifestations are quite usual, and some have reported insanity as one of the possible results of ovarian derangement. Under certain circumstances an abnormal menopause virtually develops into a minor form of dysovarism, the varying symptoms being due to irregular periods of differing ovarian activity.

The most common symptoms of dysovarism are pain in the pelvis and severe asthenia. The extreme prostration and weakness is doubtless due to a superinduced hypoadrenia, and may be the outstanding feature of a case. In most cases on bimanual palpation the offending organ or organs frequently will be found to be nodular, irregular, enlarged and tender. Here again surgery is the proper remedial procedure.

The Male Gonads.

Perhaps the dysfunctions of the testes do not require a comprehensive outline, for we are better acquainted with the results of increased or decreased physiological activity of these glands. Hypogonadism virtually means

essential infantilism, sexual insufficiency and maldevelopment as cryptorchidism and impotence. Naturally neurasthenia is common in such cases and it must be expected that this disorder is by no means limited to the essential sex glands, because of their intimacy with the other glands of internal secretion.

Infantilism.

There are several clinical forms of testicular disorder: Infantilism is the condition in which the glands are poorly developed or absent. Here the results are much the same as in hypovarism, the form and function is changed, the bodily growth is altered and the secondary sexual characteristics which normally should show themselves at puberty do not materialize.

The testicles are very small, the scrotum atrophied and the penis short and incapable of erection. Infantilism may vary in degree and developmental changes are not always necessarily accompanied by absolute inactivity of the interstitial cells of Leydig. In this case, there may eventually be possibilities of sexual desire and azoospermia may be absent.

Cryptorchidism.

The developmental anomaly known as cryptorchidism is not rare; but cases with permanent cryptorchidism are very uncommon. There may be two forms, the abdominal and the inguinal. Occasionally this condition, also known as "undescended testicle" is accompanied by testicle maldevelopment with lack of all the functions dependent upon proper activity of the Leydig cells. Again despite complete burial of the testes, they may be functionally active, in which case there is sterility in individuals none the less potent; the sterility being purely mechanical rather than functional. Such cases are not subject to the same degree of asexual-

ism as in pure infantilism or in castrates.

Eunuchoidism.

Eunuchoidism is presumed to be an acquired disorder of the interstitial cells of Leydig and those with this disturbance are quite similar in functional incapacity to a castrate but without the absence of the testes. Here there is complete functional loss of the sex principle later in life, so that the more marked manifestations of infantilism are not present.

The eunuchoid is so named from the similarity in form to the eunuch or castrate, and in addition to the retrogressive changes in the secondary sex characteristics—avitilism, reduction of facial, axillary and pubic hair, genital atrophy, there is an acquired corpulency due to the loss of the powerful oxidizing principle produced in the interstitial cells. Eunuchoidism may be due to disease or be a spontaneous hormonically produced disorder and it is accompanied by a loss of the factors dependent upon active sex-gland function—assertiveness, courage, animation and sexual power. The ergograph has been very effectively used to demonstrate the actual loss of energy and power following disease or injury to the gonads as well as to show the energizing influence of suitable organotherapy or the most recent work by Lydston and others with sex gland transplantation.

Functional Sexual Disturbances.

Many a monograph has been written on this subject and it is far too large to be considered here. Impotence, prenenility and senile testicular insufficiency have always been a subject of perennial interest. From a diagnostic standpoint the principal symptoms are lack of sexual desire and power and "sexual neurasthenia" with its innumerable manifestations. According to Williams, functional testicular disorders, espe-

cially on the side of deficiency, are known to cause general depression, hysteria, hypochondria, melancholia and also digestive disturbances.

It may be well to recall that the fundamental basis of modern organotherapy and the "fillip" which restarted the study of the age-old study of organ medication was the use by Browne-Sequard of testicular extract on himself. The dynamogenic influence of this sort of treatment then as now, is unquestioned; but for various reasons this form of treatment has never assumed the importance that it really deserves.

Undoubtedly there is such a condition as hypergonadism; but in most cases we have to meet the origin is psychic and usually beyond the control of ordinary medical treatment. From a diagnostic standpoint it is not difficult to determine.

715 Baker-Detwiler Bldg.

Next month: **The Parathyroids and Pineal Gland.**

PRACTICAL POINTS

When in doubt, follow the golden rule.

When in doubt, try to clarify matters by the use of all legitimate means at your command.

When in doubt, the diagnosis may be helped by the X-ray.

When in doubt, remember that it is no disgrace to seek consultation.

When in doubt, try KI.

When in doubt, you are not the only fellow who was ever in that condition.

When in doubt, do some real study of the case.

When in doubt, don't neglect the laboratory findings.

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EDITORIAL

PHILIP MILLS JONES.

Dr. Philip Mills Jones died of pneumonia November 27th at his home in San Francisco. Dr. Jones was secretary of the Medical Society of California, a trustee of the American Medical Association, and editor of the California State Medical Journal. He was born in 1870, graduated from the Long Island College Hospital, New York, in 1891, and began practice in California in 1893. Aside from his attainments in the medical profession, Dr. Jones made a name as an archaeologist. He spent several years traveling in South America and among the South Sea Islands, making a collection for Mrs. Phoebe Hearst, which is now at the University of California. He was considered an authority on English relics.

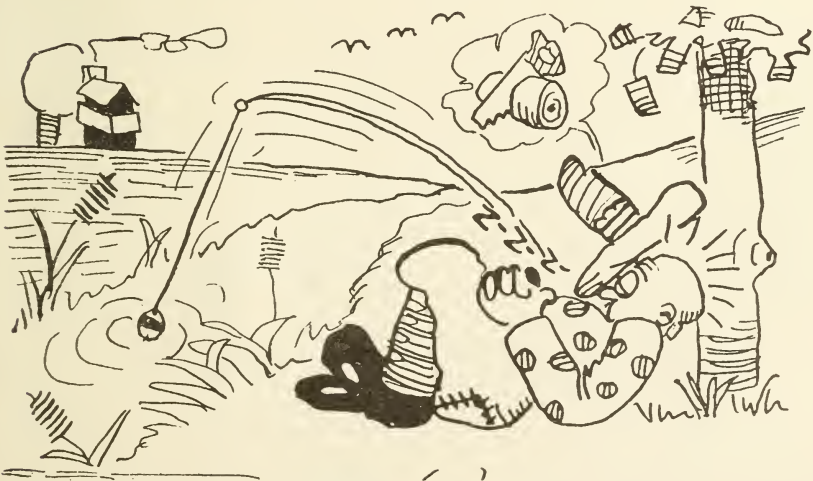
Mrs. Jones was taken to St. Luke's Hospital critically ill with pneumonia less than 24 hours before the doctor died, and passed away November 28th. She had apparently been infected from her husband. Mrs. Jones was Helen Spaulding, daughter of the late Rev. Dr. Spaulding.

Dr. P. M. Jones was one of the best known characters in the medical profession of California. As a fighter he was not always fair, but he was absolutely fearless and apparently indefatigable. In this connection it is only just that we should state our belief that he was not personally responsible for many of the vituperative editorials that appeared in the State Medical Journal, except in so far as his sense of loyalty led him to assume such responsibility. To his credit must be placed a large share of the defense of the profession and the physical welfare of the people of the state, both through organization of the profession and the securing of beneficial legislation against incompetence and quackery. Our profession may well do him homage. It is unfortunate that such lavish expenditure of energy on behalf of the profession and the people of the state should meet such meager reward this side of eternity. His spirit may well rejoice in the victories scored. Our profession will miss him sorely in our strife for higher ideals and the abolition of quackery in its many and varied forms.

DOCTORS' VACATIONS.*



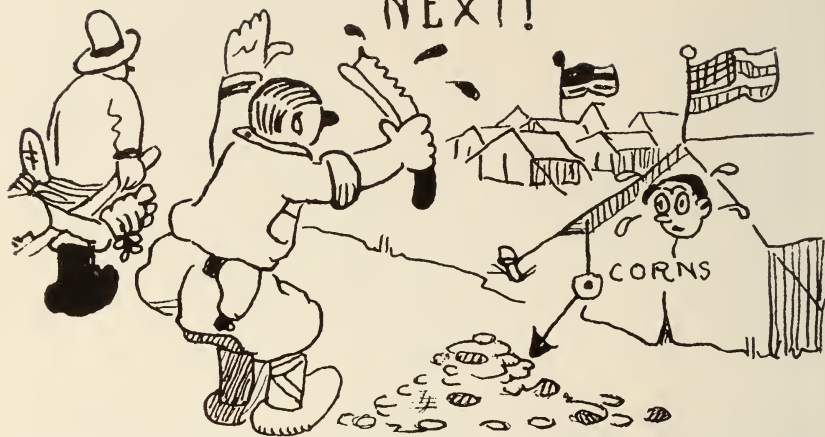
Dr. Dillon ignored the S. P. and P. E. R. R.'s and did his own transportation.



Dr. C. H. Montgomery enjoyed a very strenuous fishing trip in the High Sierras.

*As depicted by Mr. Stivers, the nephew of our Associate Editor, Dr. Stivers. Possibly the appended text is unnecessary, save for those unfamiliar with the appearance of the gentlemen in vacation attire. Sorry we didn't have room for the rest of you.

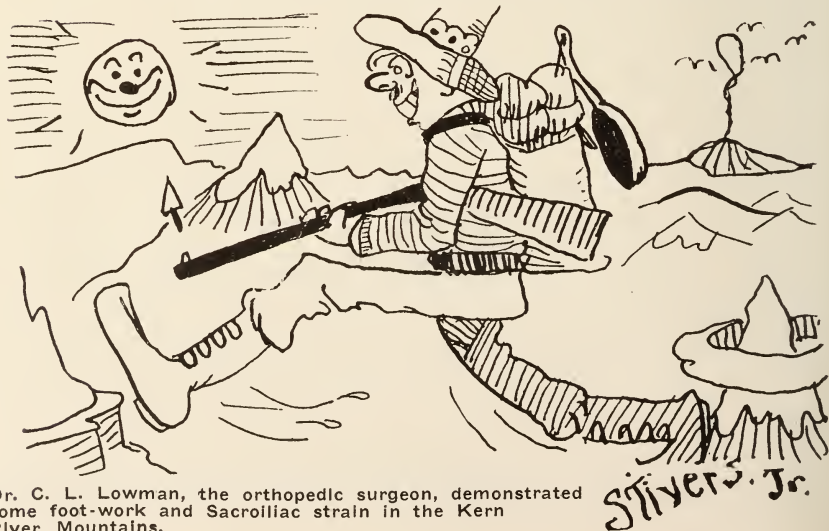
NEXT!



Dr. Lloyd Mills harvested quite a corn crop at Monterey Preparedness Camp.



Dr. Decker made some long and deep incisions at Nogales.



Dr. C. L. Lowman, the orthopedic surgeon, demonstrated some foot-work and Sacroiliac strain in the Kern River Mountains.

Stivers, Jr.

EDITORIAL NOTES

For Sale—Physicians' reception room and private office equipment, furniture, instruments, books, etc. Office open from 10 to 2 daily. 220 Wright & Calender Bldg., Los Angeles. Res. phone, 597295; office phone, M. 377.

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BOOK REVIEWS

THE PRACTITIONER'S VISITING LIST FOR 1917. Four styles: weekly, monthly, perpetual, sixty-patient. Pocket size, substantially bound in leather with flap, pocket, etc.; \$1.25, net. Lea & Febiger, Publishers, Philadelphia and New York.

It affords a simple and complete system for keeping the records of daily practice. In addition to the ruled pages for daily calls and their notes, general memoranda, addresses, cash account, etc., it contains specially arranged spaces for data desired for permanent record such as births, deaths, etc. The value of such records is best appreciated by the physician who has been suddenly confronted by the necessity of producing such data after the lapse of years and in the absence of an orderly system for their preservation.

It is issued in four styles to meet the requirements of every practitioner: "Weekly," dated, for 30 patients; "Monthly," undated, for 120 patients per month; "Perpetual," undated, for 30 patients weekly per year, and "60 Patients," undated, for 60 patients weekly per year.

A PRACTICAL MEDICAL DICTIONARY. Of words used in Medicine with their Derivation and Pronunciation, including Dental, Veterinary, Chemical, Botanical, Electrical, Life Insurance and Other Special Terms; Anatomical Tables of the Titles in General Use, and those sanctioned by the Basle Anatomical Convention; Pharmaceutical Preparations, Official in the U. S. and British Pharmacopoeias and contained in the National Formulary; Chemical and Therapeutic Information as to Mineral Springs of America and Europe, and Comprehensive Lists of Synonyms. By Thomas Lathrop Stedman, A.M., M.D., Editor of the "Twentieth Century Practice of Medicine," of the "Reference Handbook of the Medical Sciences," and of the "Medical Record." Fourth revised edition. Illustrated. New York. William Wood & Company. 1916.

In the present (fourth) edition of this dictionary, appearing just two years after the third, some hundred or more medical men make their bow and take their places among the "eponyms," as authors of tests, discoverers of reflexes, inventors of surgical and other procedures, etc.; a large number of words relating especially to colloid chemistry and to heredity have been inserted; a number of "units" and other terms in the domain of radioactivity have been collected; and other

new titles (including many belonging to dentistry) to the number in all of nearly two thousand have been added—the majority born in the short space of two years. Medicine must indeed be a progressive science if its language grows at such a rate. In former editions the terms of the Basle Anatomical Nomenclature (BNA) were indicated only when they differed from those in common use; in the present edition all these terms are marked, even when they do not differ from the vernacular.

MEDICAL RECORD VISITING LIST.

This is one of the best visiting lists on the market. It is issued in various styles to accommodate from thirty to ninety patients per week, printed with or without dates, in red or black morocco binding, with or without flap, and with or without seal or calf skin wallets attached, at prices ranging from \$1.25 to \$4.00. Published by William Wood & Company, 51 Fifth Avenue, New York.

THE PRACTISE OF UROLOGY. A Surgical treatise on Genito-Urinary Diseases including Syphilis. By Charles H. Chetwood, M.D., LL.D., F.A.C.S., Professor of Genito-Urinary Surgery, New York Polyclinic; Visiting Surgeon to Bellevue Hospital, (L. I. City), Nassau Hospital, (Mineola), White Plains Hospital; Member American Association of Genito-Urinary Surgeons, American Urological Association; L'Association Internationale D'Urologie, Etc. Profusely Illustrated, Second Edition. New York: William Wood & Company, 1916. Price \$5.50 net.

The changes and additions involve: First, the department of cystoscopy, wherein the method of teaching this branch has been expanded and set forth in greater detail. Second, there have been some additions to the operative technic. An example is the simple method, devised by the author's associate and chief of staff, Dr. Sinclair, of surmounting the difficulties encountered in impassable stricture, by suprapubic puncture and retrovesical urethrotomy. Third, there has been added a section on local anesthesia, so far as it lends itself effectively to this department of surgery. Other minor changes appear

here and there throughout the different chapters. Finally, the use of salvarsan, new and old, has been given additional attention, having become a fixed and indispensable factor in the treatment of all cases of syphilis.

THE PRACTICAL MEDICINE SERIES.

Comprising ten volumes on the year's progress in medicine and surgery. Under the general editorial charge of Charles L. Mix, A.M., M.D., Professor of Physical Diagnosis in the Northwestern University Medical School. Volume VI. **GENERAL MEDICINE**, Edited by Frank Billings, M.S., M.D., Head of the Medical Department and Dean of the Faculty of Rush Medical College, Chicago. Assisted by Burrell O. Raulston, A.B., M.D., Resident Pathologist, Presbyterian Hospital. Series 1916. Chicago. The Year Book Publishers, 327 S. La Salle Street. Price of separate volumes is \$1.50, and of the ten volumes \$10.00.

The literature of the year is especially full and interesting. The European war has been the direct or indirect factor in a great increase in the incidence of infectious disease. The reader will find much of interest in the wider knowledge gained by a study of typhoid, typhus, cholera, trench fevers, and other diseases so prevalent in the countries at war. Preventive medicine has been wonderfully successful in the control of communicable diseases. Prophylactic vaccination against typhoid and paratyphoid fevers and cholera has been widely and successfully practiced. The deplorable, destructive and barbaric war has emphasized the humanizing influence of medical knowledge and practice.

THE BLAKISTON PHYSICIAN'S VISITING LIST FOR 1917

includes an entirely new dose list prepared in accordance with the new United States Pharmacopoeia. This will prove an exceedingly useful feature, as there were many changes, improvements in standards, new drugs and other material inserted. This list gives the dose in both the apothecary and metric systems and the solubility and important incompatibilities when called for. Several other new tables have been inserted such as isolation periods in infectious diseases, table of mortality, etc. P. Blakiston's Son & Co., Philadelphia.

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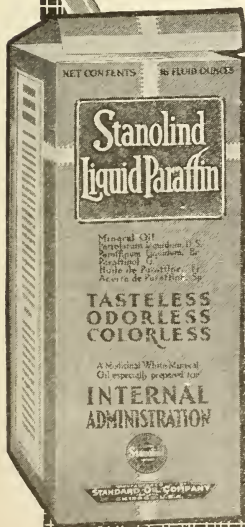
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A TEXT-BOOK OF HISTOLOGY. By Frederick R. Bailey, A.M., M.D., Fifth Revised Edition. Profusely Illustrated. New York: William Wood & Company, 1916. Price \$3.75 net.

The writer in the preparation of these pages has given to the student of medicine a text-book of histology suitable for use in connection with practical laboratory instruction. The text has been made as concise as possible consistent with clearness, and the writer made the more essential elements stand out somewhat from the necessarily accompanying details. It has been impossible to accomplish this without some sacrifice of uniformity of treatment and of logical sequence. This made much fuller and more "practical" especially noticeable in the chapter on the nervous system, which has been tical" than is usual.

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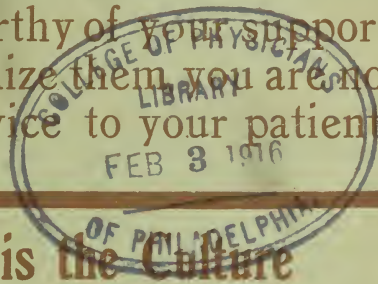
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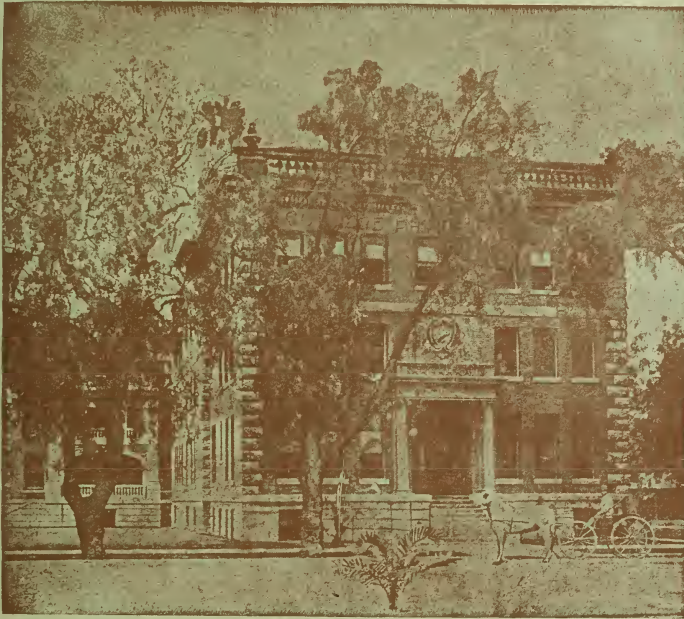
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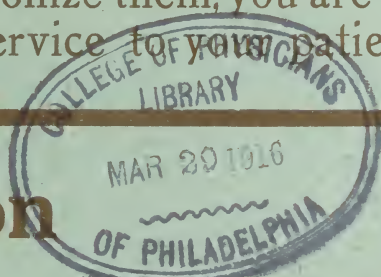
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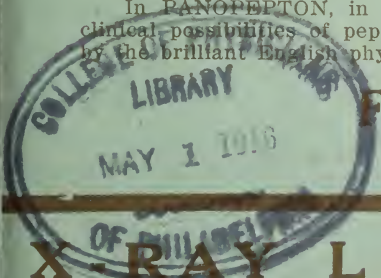
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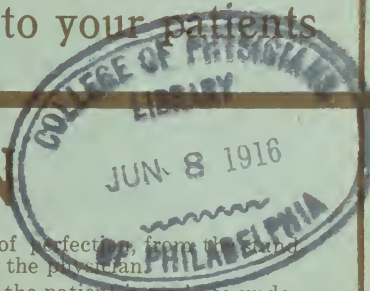
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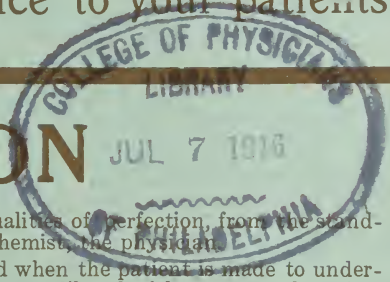
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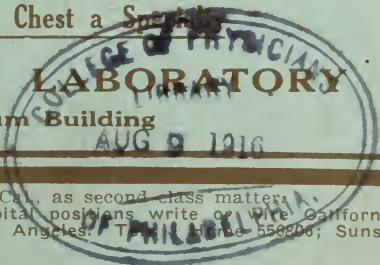
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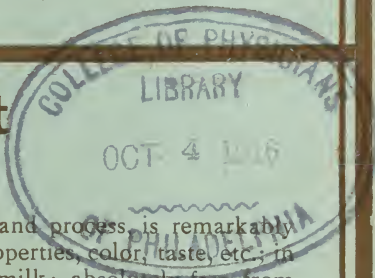
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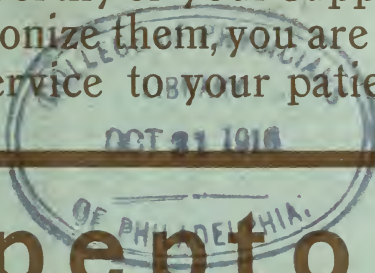
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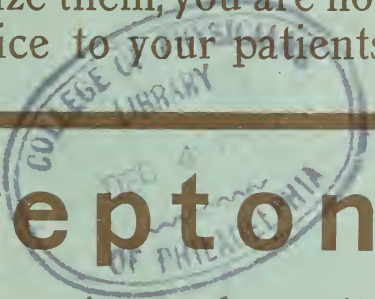
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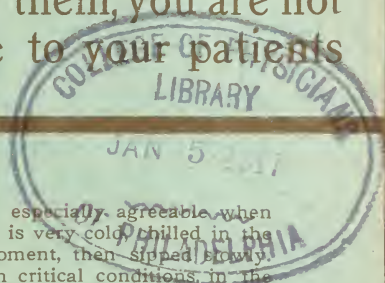
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